Cygnet Health Care Limited

Cygnet Hospital Taunton

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

Cygnet Hospital Taunton is an independent mental health hospital near Taunton in Somerset, providing a range of specialist mental health services. This can include people detained under the Mental Health Act and those with challenging behaviour, as well as patients with long-term mental illness and additional physical health conditions.

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

- There had been significant improvements on the acute inpatient ward since the previous inspection in 2019. The hospital had separated the acute inpatient ward into two wards; namely Sycamore 1 and Sycamore 2.
- There was a new leadership team since our last inspection in 2019 who had a clear plan in place for the site and had started to make progress. The new hospital manager was aware of the risk areas and performance issues facing the service. They had reviewed the site improvement plan and had developed this in response to the identified areas for improvement, and progress with this was already evident. Staff said there had been a positive shift in culture.
- The service provided safe care. All ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed environment and individual risk well. They minimised the use of restrictive practices such as the use of seclusion and restraint, 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 such as National Early Warning Score (NEWS2). NEWS2 is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, these are recorded in routine practice, when patients are in hospital. Staff engaged in clinical audit to evaluate the quality of care they provided such as The National Audit of Dementia (NAD).
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. These included Speech and Language Therapy (SALT) and Occupational therapy. Managers ensured that these staff received training, including specialist training to support them to meet the needs of patients, regular supervision and an annual 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 such as mental health community teams which is delivered mostly by the local NHS trusts.
- 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. Most patients we spoke with told us most staff were caring and treated them with respect and kindness. The hospital held daily reflection meetings, and weekly community meetings. Patients were encouraged to raise any issues, compliments and complaints during these meetings.
- 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. Staff we spoke with talked positively about their roles and were passionate about the service developing. Staff felt able to raise concerns without fear of victimisation and spoke positively about the organisation.

However:

Summary of findings

- Documentation around mental capacity was not always clear on Sycamore ward 1 and 2. It was difficult to identify mental capacity assessments in records. Some records identified that capacity was assessed and documented as patient having “insight” whilst other records identified that “patient had capacity” and these were recorded in different parts of the record keeping tool the hospital used. This meant it was not always clear if a patient had capacity to make a specific decision.
- Staff on Swift ward did not always carefully plan patients’ discharge. Staff did not always complete the fit to travel assessment documentation to ensure patients could travel safely once discharged.
- Carers that we spoke with expressed their frustration with contacting the wards via telephone regarding visit access during Covid-19 outbreaks at the hospital. Carers told us that it could sometimes take multiple phone calls in one day to get through to ward staff and get conflicting messages regarding visit access.
- The hospital lacked a robust assurance system to verify the training status of agency staff. Managers we spoke with told us they requested agency staff who had completed certain training but were not able to verify if this training actually took place.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Good 	See the overall summary.
Acute wards for adults of working age and psychiatric intensive care units	Good 	See the overall summary.
Wards for older people with mental health problems	Good 	See the overall summary.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Hospital Taunton

Cygnet Hospital Taunton is an independent mental health hospital near Taunton in Somerset, providing a range of specialist mental health services. This can include people detained under the Mental Health Act and those with challenging behaviour, as well as patients with long-term mental illness and additional physical health conditions. There are five wards within the hospital at the time of inspection. Sycamore 1 ward and Sycamore 2 ward are male acute inpatient wards, with nine and 17 beds respectively. Peacock ward is a four bedded step down, pre-discharge ward. Redwood Ward is a nine bedded locked ward for men with a mild to moderate learning disability or autistic men. Swift ward is a 15 bedded ward which supports older people both male and female with mental health difficulties.

At the time of this inspection the hospital had a registered manager in post. The hospital is registered to provide two regulated activities; treatment of disease, disorder or injury and assessment or medical treatment of persons detained under the Mental Health Act 1983.

The older adult ward and the learning difficulty wards were last inspected in March 2019 and was awarded a rating of good. The acute wards were inspected in December 2019 and was rated as requires improvement.

During our inspection in March 2019 we told the provider that they must make improvement to ensure that the dignity and privacy of patients was maintained.

During our inspection in December 2019 we told the provider that they must make improvement to:

ensure that the ward areas are clean, that there is always sufficient staff to ensure safe, good quality care, that patients are observed appropriately, that risks are clearly documented in patients notes, that capacity assessments are undertaken in a timely manner, staff receive appropriate induction, support, training, professional development and supervision and that there are effective governance systems in place to monitor and support the development of staff.

During this inspection we were satisfied that the above requirements were met.

What people who use the service say

Most patients we spoke with told us most staff were caring and treated them with respect and kindness. We observed staff engaging with patients in a kind and caring way. Patients on Redwood ward reported that “staff always support us with our care, they helped us understand what was happening”.

One carer told us that all the staff on the wards were friendly and that their relative knew every member of staff working on the ward. However, one carer told us they did not feel included in their relative’s care and treatment. For example, they said they had not been given any information about why their relative had been admitted, what their diagnosis was or what medication was prescribed and why. One carer told us the clinical team did not have the right information about their relative and was dismissive of their concerns. Carers whose relatives were from the acute inpatient ward expressed their frustration with contacting the wards via telephone regarding visiting access during Covid-19 outbreaks at the hospital. Carers told us that it could sometimes take multiple phone calls in one day to get through to ward staff and get conflicting messages regarding visit access.

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. During the inspection visit, the inspection team:

- visited Swift ward, Redwood ward, Sycamore 1 and 2 ward and Peacock ward. We looked at the quality of the environment
- spoke with 17 staff members including, the ward manager, ward clerk, nurses, support workers, head of occupational therapy, occupational therapist, occupational therapy assistant, active life co-ordinator and a doctor.
- conducted a check of the clinic room and reviewed six patient medication records
- spoke to 10 carers
- spoke to 10 patients
- reviewed 26 patient care and treatment records
- reviewed seven staff supervision records and team meeting minutes
- reviewed records of six incidents and six complaints
- attended and observed a patient meeting and a multi-disciplinary team meeting
- carried out a specific check of 25 medication charts
- looked at a range of policies, procedures and other documents relating to the running of the service.
- looked at complaints, concerns and compliments
- reviewed the safeguarding statistics and reports and
- we engaged with four people who use the service using Talking Mats communication tool.

Our inspection team comprised of four inspectors, two specialist advisors and three experts by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example, as a carer.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance the Care Quality Commission follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

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

Outstanding practice

We found the following outstanding practice:

Summary of this inspection

Redwood ward used a wide range of communication methods to support patients with communicate effectively. They used a range of visual information talking buttons. For example, menus were in visual written, pictures and talking button formats, activities were available in the same variety of formats. Talking buttons also gave the instruction to contact staff members if they were still uncertain about the information given.

The talking buttons were in a clear softly spoken voice giving information to people who could not read, they were situated in the same area as the written and pictorial information so as not to make anyone feel inferior in any way, and staff felt that these information stations helped a great deal towards reducing frustrations in communication and a more relaxed approach for the individuals using the service causing far less anxiety, and ultimately possible reduction in challenging behaviours.

Areas for improvement

Action the service SHOULD take to improve:

Provider Level:

- Information should be available to the service so they can be assured that agency staff training is up to date and relevant to their role.

Acute Inpatient Mental Health Ward service

The service should ensure that:

- The service should ensure that Mental Capacity assessments are recorded consistently in the relevant record keeping tool.
- The service should consider ways to improve communication with carers to ensure it is clear and consistent from all staff.

Older Person Mental Health Inpatient ward service

The service should ensure that:

- The service should ensure that staff complete the fit to travel assessment documentation to ensure that patients are able to travel safely once discharged.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Good	Good	☆ Outstanding	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Good

Is the service safe?

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

Safe and clean care environments

The environment was clean and very well maintained, and the ward was very well equipped with appropriate aids and adaptations to meet people's needs.

Throughout the tour of the ward, the inspection team observed that there were no obvious ligature risks that were not managed effectively and the risk assessment mirrored this.

There were good lines of sight and these were supported by the use of mirrors and closed-circuit television (CCTV) was in place throughout the ward but not in bedrooms and was used for the purpose of reviewing incidents only.

Safe and clean care environments

People were cared for on the ward, which was safe, clean well equipped, well furnished, well maintained and fit for purpose.

People were cared for on the ward, where staff had completed risk assessments of the environment and removed or reduced any identified risks.

The service minimised and prevented visitors from catching and spreading infections by using good infection control and availability of Personal Protective Equipment (PPE) and hand sanitising facilities. All staff were wearing masks whilst on duty.

Good

Wards for people with learning disabilities or autism

People were admitted safely to the ward, isolation protocols adhered to and other professionals and family members updated regularly of the current Covid 19 status. All policies and protocols were reviewed regularly to make changes enforced by government guidelines

Staff checked, maintained, and cleaned equipment. Cleaning records were seen and evidenced as correct and in date. These were reviewed by the Ward Manager weekly and discussed at the morning meeting if applicable to current activity.

Safe staffing

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

The service had enough staff, including for one-to-one support for people to take part in activities and visits how and when they wanted. There were always two registered nurses on duty every shift, one Registered Nurse in Learning Disabilities (RNLD) and one Registered Nurse in Mental Health (RNMH) and the same on the night shift.

There were also three support workers on duty and additional support from the occupational therapist, occupational therapy assistant, and a preceptee psychologist.

The numbers and skills of staff matched the needs of people using the service and the ward was almost up to its full complement of staff. When needed they used some regular agency staff who knew the people who use the service and people told us they felt comfortable with the agency staff. They also used regular agency staff on nights, but in both situations, the ward was endeavouring to recruit to their full quota of permanent staff by the end of May 2022. They had undertaken a recruitment drive and were also planning to recruit from abroad.

We reviewed six files for regular agency staff. Two of them contained photocopied certificates of training, however despite the compliance manager reassuring us that this was the new way forward for recording, the other four files did not contain any of this evidence. Although the certificate training checklist stated training was completed, it was unclear if the agency had any sight of these.

Of the five agencies regularly used by the service, all were now aware that photocopies of the certificates were now expected to be presented to the provider for evidence of completed training. Certificates were to evidence the staff having completed statutory and mandatory training with the Agency

Staff knew how to take into account people's individual needs, wishes and goals and this was reflected in the care plans and individual risk assessments. Plans for the future and goals and wants.

Managers arranged shift patterns so that people who were friends or family did not regularly work together, this was reflected in the duty rota, which was evidenced on the ward.

Every person's record contained a clear one-page profile with essential information so that new or temporary staff could see quickly how best to support them.

Managers made sure all bank and agency staff had a full induction and understood people's needs before starting their shift. This was reflected in the use of regular agency staff who were familiar with the ward and individuals using the service.

Good

Wards for people with learning disabilities or autism

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

The ward manager could adjust staffing levels according to people's needs. If levels of observation were increased there was no hesitation in increasing the staffing levels.

People had regular one-to-one sessions with their named nurse, this was something the people using the service highlighted and said they went out with their named nurse as well. They always felt confident to ask for time with their named nurse.

People did not have their escorted leave or activities cancelled, even when the service was short staffed, as this was deemed an important part of the daily/weekly routine and wellbeing, as well as their future planning training.

The service had enough staff on each shift to carry out any physical interventions safely. Staff made every attempt to avoid restraining people and did so only when verbal de-escalation techniques had failed and when necessary to keep the individual or others safe.

The approach to problem solving/ reduction in challenging behaviour, was verbal de-escalation and one to one time once the situation was safe to do so.

No restraints had been recorded for the last three months prior to the inspection.

Staff shared key information to keep people safe when handing over their care to others, and this was evidenced at the morning handover meetings and in the individual files in their notes.

The service had enough daytime and night-time medical cover, and a doctor was available to go to the ward quickly in an emergency. The training programme was comprehensive and met the needs of people and staff.

Assessing and managing risk to patients and staff

People were cared for safely and free from unwarranted restrictions because the service assessed, monitored and managed safety well. All risk assessments were up to date and addressed individual's needs and requirements.

People were involved in managing risks to themselves and in taking decisions about how to keep safe. These were evidenced in all risk assessment plans.

People, including those unable to make decisions for themselves, had as much freedom, choice and control over their lives as possible because staff managed risks to minimise restrictions. They involved the individual people using the service, to make a holistic plan to manage their risk.

People's care records helped them get the support they needed because it was easy for staff to access and keep high quality clinical and care records. Staff kept accurate, complete, legible and up-to-date records, and stored them securely. Care plans and activity programmes were of a high standard and the visual information on the ward for people using the service to access, was excellent.

Good

Wards for people with learning disabilities or autism

The service helped keep people safe through sharing of information about risks. These were in the care plans but there were also visual prompts about asking for help and support, out on the ward and in a language relevant to all who use the service.

Staff managed the safety of the living environment and equipment in it well through checks and action to minimise risk. Staff completed weekly safety audits, but there was evidence of ongoing observations of safety issues as discussed in daily handover meetings.

People's freedom was restricted only where they were a risk to themselves or others, as a last resort and for the shortest time possible. The restraint audit showed that there were only episodes of gentle restraint (arm holds, verbal de-escalation). There was a total of 34 restraints of which 32 were reviewed on CCTV and recorded as such. Of those restraints 10 were in the prone position and five in supine. People were restrained only where evidence demonstrated it was necessary, lawfully justified, used for the minimum period of time, had a justifiable aim, and was in the person's best interest.

Staff could recognise signs when people experienced emotional distress and knew how to support them to minimise the need to restrict their freedom to keep them safe.

Staff considered less restrictive options before limiting people's freedom. Verbal de-escalation, quiet time and time to talk, were the first options offered. Each person's care and support plan included ways to avoid or minimise the need for restricting their freedom. Staff restricted people's freedom based only on their individual needs and risks.

Staff made every attempt to avoid restraining people and did so only when de-escalation techniques had failed and when necessary to keep the person or others safe. If a person's freedom was restricted by staff, they received emotional support when needed.

All restrictions of people's freedom were documented, monitored and triggered a review of the person's support plan.

Staff knew about any risks to each person, and prevented or reduced risks, by positive engagement, and knowing what was best the individual and how to manage their anxieties and distress.

Staff identified and responded to any changes in risks to people or posed by them. These were also discussed at the multi-disciplinary team (MDT) meeting and adjustments made if deemed appropriate.

Staff followed National Institute for Health and Care Excellence's (NICE) guidance when using rapid tranquilisation. Qualified Nurses were able to relay information and process around rapid tranquilisation.

Where staff were trained in the use of restrictive interventions, the training was certified as complying with the Restraint Reduction Network Training standards. All staff attended training on induction. Updates were identified by the ward manager when required.

If staff restricted a person's freedom, they took part in post incident reviews and considered what could be done to avoid the need for its use in similar circumstances. There was always a de-brief for the individual and staff following an incident.

Good

Wards for people with learning disabilities or autism

People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse. The service worked well with other agencies to do so. There was details about advocates and freedom to speak up guardians available to contact. The freedom to speak up guardian offered regular meetings to keep staff updated with any changes.

Staff had training on how to recognise and report abuse and they knew how to apply it. This was high profile on the ward. Staff attended a training session to input into the development of the Oliver McGowan Learning Disability Training Project.

People and those who matter to them had safeguarding information in a form they could use, and they knew how and when to raise a safeguarding concern. There was good safeguarding knowledge amongst staff and training for everyone.

Staff understood how to protect people from abuse and the service worked well with other agencies to do so.

Staff knew how to recognise adults at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were safeguarding meetings held on a regular basis and audits to evidence this. The hospital had a designated safeguarding lead.

Managers took part in serious case reviews and made changes based on the outcomes. There was a good “lessons learned” audit and regular updates following incidents and accidents.

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – which were electronic.

Medicines management

The service ensured people’s behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of Stop Overmedication of People with Learning Disabilities and Autism or both (STOMP) and ensured that people’s medicines were reviewed by prescribers in line with these principles.

Stop Overmedication of People with Learning Disabilities and Autism or both (STOMP) was being championed on the ward and the people using the service were aware of what this was and what was being done, again some very good and detailed pictorial evidence giving explanation in several different formats to meet the different cognitive abilities.

People received support from staff to make their own decisions about medicines wherever possible. These were discussed during assessment and weekly in the multi-disciplinary team (MDT). The responsible clinician (RC) made the individuals aware of what the medication was for and how it would work. Information sheets were available again in a variety of formats.

People could take their medicines in private when appropriate and safe. The clinic room was very small but privacy was respected.

Staff followed effective processes to assess and provide the support people needed to take their medicines safely. This included where there were difficulties in communicating, individual needs were assessed as to swallowing risk, concerns about the type of medication and what the side effects could be.

Staff reviewed each person's medicines regularly to monitor the effects on their health and wellbeing and provided advice to people and carers about their medicines.

Staff followed national practice to check that people had the correct medicines when they moved into a new place or they moved between services.

Staff reviewed the effects of each people's medication on their physical health according to NICE guidance. Physical health checks were made and recorded on National Early Warning Score (NEWS) as to any side effects experienced from prescribed medication.

People received their medicines from staff who prescribed, administered, recorded and stored their medicines safely.

The team were supported by the community pharmacist, and they used the Ashtons system for recording.

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 were aware of what incidents were and knew how to report them and to whom they should report them. They were all aware of the reporting system online and knew how to complete an incident/accident form and submit it.

Staff reported serious incidents were reported in line with the provider's policy and procedures. All staff were given training on this during their induction period and practised on the ward when required to do so.

Staff we spoke to had good understanding of the duty of candour and the need to be open and honest with people using the service and their families. The families were informed of any issues that may have arisen in the care of their family member.

Following all incidents, the ward manager held a de-brief for all staff and people using the service who the incident may have affected and their families if appropriate. These issues were discussed at the weekly MDT and lessons learned considered.

Lessons learned were shared so such incidents were not be repeated and to promote any achievable improvement in care. There are monthly lessons learned meetings for the ward and staff are encouraged to participate and contribute. Minutes of the meetings are kept on the ward by the ward manager. The lessons learned process was also discussed during supervision, and there was a champion who can help and support at other times, who presents the forum.

During in house training the ward manager or senior staff will often present a topic for discussion, educational purposes and lessons learned can be part of these presentations. For example, safety issues, observation levels what they mean and how to implement safely, patient engagement, peer support systems, Positive Behavioural Support.

Good

Wards for people with learning disabilities or autism

Are Wards for people with learning disabilities or autism effective?

Good

Our rating of effective stayed the same. We rated it as Good

Assessment of needs and planning of care

Staff completed a comprehensive assessment of each person's physical and mental health either on admission or soon after. They would be seen by a doctor on the day they were admitted.

People using the service had care and support plans that were personalised, holistic, strengths-based and reflected their needs and aspirations, including physical and mental health needs. Any particular requests or concerns important to them were recorded and staff reviewed plans regularly together with the people using the service.

Care plans reflected a good understanding of people's needs, including relevant assessments of people's communication support and sensory needs. There was a vast array of communication visuals and written documents available to all people using the service, explaining about the Ward and hospital, and a very informative Redwood Ward information pack which addressed individual's needs.

Staff ensured people had up-to-date care and support assessments, including medical, psychological, functional, communication, preferences and skills, all of which were developed together with named nurses, MDT members and the person using the service.

Support plans set out current needs, promoted strategies to enhance independence, and demonstrated evidence of planning and consideration of the longer-term aspirations of each person.

There were clear pathways to future goals and aspirations, including skills teaching in people's support plans. Occupational therapy staff worked with people using the service to co-produce forward planning plans which focused on skills and goals.

Best practice in treatment and care

Staff supported people with their physical health and encouraged them to live healthier lives. This included access to psychological therapies, support for self-care and the development of everyday living skills.

Staff were aware of and followed best practice and the principles of right support, right care, right culture.

Staff understood people's positive behavioural support plans and provided the identified care and support. All people who use the service had a positive behaviour support plan.

Staff made sure people had access to physical health care, including specialists as required.

Staff met people's dietary needs and assessed those needing specialist care for nutrition and hydration.

Good

Wards for people with learning disabilities or autism

People were supported by staff in line with their moving and handling risk assessments and care plans.

Staff helped people live healthier lives by supporting them to take part in programmes or giving advice.

Staff took part in clinical audits, benchmarking and initiatives. Managers used results from audits to make improvements.

Skilled staff to deliver care

People received good care as managers supported staff through regular, constructive clinical supervision of their work.

People were supported by staff who had received relevant and good quality training in evidence-based practice. This included training in the wide range of strengths and impairments people with a learning disability and or autistic people may have, mental health needs, communication tools, positive behaviour support, trauma-informed care, human rights and all restrictive interventions. Staff were supported to apply their training to people's individual needs.

The hospital delivered in house specialist training sessions run by a variety of staff to meet identified learning needs and to implement lessons learnt.

Staff could describe how their training and personal development related to the people they supported. Updated training and refresher courses helped staff continuously apply best practice to the people they cared for.

People benefitted from reasonable adjustments to their care to meet their needs, and their rights were respected. This was because staff put their learning into practice.

Staff were knowledgeable about and committed to using techniques which reduced the restriction of people's freedom. If staff had to restrict people's freedom they held debriefing meetings and reflected on their practice to consider improvements in care.

Staff received support in the form of continual supervision, appraisal and recognition of good practice. This created a positive work culture.

The service had clear procedures for team working and peer support that promoted good quality care and support.

Staff responsible for the surveillance and recordings of the CCTV system were trained according to relevant codes of practice and legislation.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care.

The ward team had effective working relationships with staff from services that would provide aftercare following people's discharge and engaged with them early on in people's admission to plan discharge.

Good

Wards for people with learning disabilities or autism

People had health action plans or health hospital passports that enabled health and social care services to support them in the way they needed.

The service ensured that people were registered on their GP's quality and outcomes framework, so that any reasonable adjustments were made to meet their individual needs. Multidisciplinary team professionals were involved in or made aware of support plans to improve care.

Staff shared clear information about people and any changes in their care, including during handover meetings.

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

Staff understood their roles and responsibilities and were able to explain people's rights to them.

Staff explained to each person their rights under the Mental Health Act in a way that they could understand, repeated it as necessary and recorded it clearly in the people's notes each time.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician or the Ministry of Justice or both.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of people's detention papers and associated records correctly, and staff could access them when needed.

Care plans included information about after-care services available for those people 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.

Staff ensured people had an Independent Mental Health Advocate or were offered one as needed.

Good practice in applying the Mental Capacity Act

Staff supported people to make decisions on their care for themselves. They assessed and recorded capacity clearly for people who might lack the mental capacity to make certain decisions for themselves.

Staff empowered people to make their own decisions about their care and support and obtained people's consent in an inclusive way.

Staff ensured that an Independent Mental Capacity Advocate was available to help people if they lacked capacity to make decisions for themselves and they had nobody else to represent their interests.

Staff were aware of people's capacity to make decisions through verbal or non verbal means, and this was well documented.

Good

Wards for people with learning disabilities or autism

For people that the service assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any decisions made on their behalf in their best interests. This was supported by effective staff training and supervision.

Staff followed best practice on assessing mental capacity, supporting decision-making and best interest decision-making.

For people lacking capacity to make decisions about their medicines, staff followed best practice. The service followed safe processes when giving people medicines covertly. Staff respected the rights of people with capacity to refuse their medicines and ensured that people with capacity had the option to consent to receiving medicines.

Staff gave people all possible support to make specific decisions for themselves before deciding they did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a person needed to make an important decision. When staff assessed people as not having capacity to make decisions for themselves, they made decisions on people's behalf in their best interest and considering their wishes, feelings, culture and history.

People's freedom was restricted only when necessary and staff made applications for a Deprivation of Liberty Safeguards authorisation where needed, or a deprivation of liberty was made through a court process.

People had easy access to information about independent mental health advocacy, and people who lacked capacity to make decisions for themselves were automatically referred to the service.

People were consulted and included in the decisions about the use of surveillance. They were provided with information regarding all aspects of the surveillance, including records management, to enable them to give informed consent.

Are Wards for people with learning disabilities or autism caring?

Outstanding ☆

Our rating of caring improved. We rated it as outstanding.

Kindness, privacy, dignity, respect, compassion and support

Staff treated people with compassion and kindness. They respected people's privacy and dignity. They understood people's individual needs of and supported them to understand and manage their care, treatment or condition.

Staff saw people as their equal and created a warm and inclusive atmosphere. People received kind and compassionate care from staff who used positive, respectful language at a level people understood and responded well to.

Staff were patient and used appropriate styles of interaction with people. They were calm, focused, and attentive to people's emotional and other support needs and sensory sensitivities.

People felt valued by staff who showed genuine interest in their wellbeing and quality of life.

Good

Wards for people with learning disabilities or autism

People had the opportunity to try new experiences, develop new skills and gain independence. Each person had a support plan that identified target goals and aspirations and supported them to achieve greater independence including skills development.

People's rights were upheld by staff who supported them to be independent and have control over their own lives.

Staff knew when people needed their space and privacy and respected this.

Staff supported people to understand and manage their own care, treatment or condition. Staff directed people to other services and supported them to access those services if they needed help.

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

Staff followed the provider's policy to keep people's information confidential.

Involvement in care

Staff involved people in care planning and risk assessment and sought their feedback on the quality of care provided. They ensured that people had easy access to independent advocates. There were clear signs and pictures to provide this detail.

People were listened to, given time and supported by staff to express their views using their preferred method of communication. Individuals stated that they could ask for one to one time for particular activities, family contact and planning their day, support with escorted leave and time to talk.

Staff took the time to understand and develop a rapport with people. We saw very positive activity interactions with all individuals on the ward, we also saw parental involvement and people accessing their escorted leave and unescorted leave.

People were enabled to make choices for themselves. Staff ensured they had the information they needed. There were individual needs plans so each person was able to identify those activities that met their needs, physically ,medically socially and emotionally.

Staff respected people's choices and wherever possible, accommodated their wishes, including those relevant to protected characteristics – for example, due to cultural or religious preferences.

People were empowered to make decisions about the service when appropriate and felt confident to feed back on their care and support.

People and those important to them took part in making decisions and planning their care and in risk assessments.

People felt listened to and valued by staff who engaged meaningfully with them. They were given choices, shown respect and encouraged to make decisions around their needs. Choices in activities, menu planning, forward planning for discharge, which included escorting to identified placement.

Good

Wards for people with learning disabilities or autism

Staff supported people to maintain links with those important to them. Families were encouraged and were seen actively engaging with the individuals and staff team.

Staff introduced people to the ward and the services as part of their admission. They were given a full induction once settled and offered opportunities to talk about the ward, meet the staff team, familiarise themselves with the environment, meet their peers. There was a very good introduction leaflet to the ward that everyone received.

Staff made sure people understood their care and treatment and found ways to communicate with people who had communication needs. Again, the use of pictures electronic tablets, sound buttons, structured plans for the day/week

Staff informed and involved families and carers appropriately. They called about any issues arising in relation to their health and welfare, had an open invitation for families to visit when they wished, invitations to ward events.

Staff helped families to give feedback on the service. There were feedback forms available and staff encouraged families to contribute with these, they also encouraged telephone contact, emails and face to face as well as virtual contact.

Are Wards for people with learning disabilities or autism responsive?

Good

Our rating of responsive improved. We rated it as good.

Access and discharge

Staff planned and managed peoples' discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, people did not stay in hospital longer than needed, and discharge was rarely delayed for other than a clinical reason.

Managers regularly reviewed people's length of stay to ensure they did not stay longer than needed.

If a person was not from the local area staff supported them, in line with their wishes, to have regular contact with family, friends or an advocate.

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

People were moved between wards during their stay only when there were clear clinical reasons or it was in their best interests. Staff supported people when they were transferred between services.

Staff did not move or discharge people at night or very early in the morning. Staff carefully planned people's discharge and worked with care managers and co-odinators to make sure this went well.

Facilities that promote comfort, dignity and privacy

Good

Wards for people with learning disabilities or autism

The design, layout, and furnishings of the ward supported people's treatment, privacy and dignity. Each person 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 people could make hot drinks and snacks at any time.

The service's design, layout and furnishings supported people and their individual needs. This included noise-reducing furnishings and calm diffused lighting, which supported people with sensory sensitivities.

People's care and support was provided in a safe, clean, well equipped, well-furnished and well-maintained environment that met people's sensory and physical needs.

The service had quiet areas and a room where people could meet visitors in private and people could make phone calls in private. The service had an outside space that people could access easily.

Patients' engagement with the wider community

Staff supported people with family relationships and community activities outside the service, such as work, education, social activities, such as bowling, attending the gym and attending local football matches.

Staff gave people person-centred support with self-care and everyday living skills.

People were encouraged and supported by staff to reach their goals and aspirations. Planning for their future, what they would like to do and where they may want to live.

Staff helped people to stay in contact with families and carers. People who were living away from their local area were able to stay in regular contact with friends and family using the telephone, online voice or video calls, and social media.

Clear plans and placement goals were developed with commissioners to enable people to move back to their local community as soon as possible.

Staff ensured adjustments were made so that people could take part in activities.

Staff enabled flexibility and helped people to have freedom of choice and control over what they did. Staff enabled people to broaden their horizons, develop new interests and make friends.

Staff were committed to encouraging people, in line with their wishes, to explore new social, leisure and community-based activities.

Meeting the needs of all people who use the service

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

Staff used person-centred planning tools and approaches to discuss and plan with people how to reach their goals and aspirations.

Good

Wards for people with learning disabilities or autism

Staff discussed ways of ensuring targets for people were meaningful. They spent time with people understanding how they could be achieved.

Staff provided effective skills teaching because it was tailored to individual people. People learned everyday living skills, understood the importance of personal care and developed new interests by following individualised learning programmes with staff who knew them well.

Staff made reasonable adjustments to ensure better health equality and outcomes for people.

Staff identified people's preferences and appropriate staff were available to support people– for example, by having staff of people's preferred gender available to support them.

People were supported to understand their rights and explore meaningful relationships.

People were supported with their sexual/ religious/ ethnic/ gender identity without feeling discriminated against.

Staff offered choices tailored to individual peoples needs using a communication method appropriate to that person.

Staff ensured people had access to information in appropriate formats, which included photographs, symbols, electronic devices, tablets, computers, talking buttons.

Staff provided information using objects/photographs/ gestures/symbols/other visual cues, electronic tablets and computers to help people know what was going to happen during the day and who would be supporting them.

The speech and language therapist worked with patients to produce easy read care plans. People had individual communication plans/ passports that detailed effective and preferred methods of communication, including the approach to use for different situations.

Staff had good awareness, skills and understanding of people's individual communication needs. They knew how to facilitate communication and when people were trying to tell them something.

Staff worked closely with health and social care professionals and ensured people were assessed to see if they would benefit from the use of non-verbal communication aids.

Staff were trained and skilled in using personalised communication systems. People received individualised support such as tailored visual schedules to support their understanding.

Staff made sure people could access information on treatment, local services, their rights and how to complain. The service had information leaflets available in languages spoken by people and the local community. Managers made sure staff and people could get help from interpreters or signers when needed.

The preceptee psychologist and speech and language therapist had created bespoke dementia awareness training to provide education and increase awareness for patients.

The service provided a variety of food to meet people's dietary and cultural needs. People had access to spiritual, religious and cultural support.

Good

Wards for people with learning disabilities or autism

The hospital had held a number of recent events, including an International Mother Language Day run by the multicultural network ambassador. Staff and patients also worked together to plan and run a Christmas Fayre.

Listening to and learning from concerns and complaints

In the 12 months prior to the inspection there were18 informal complaints and 40 formal complaints. Of these 75% were addressed within the timeframe. In the same timeframe the service received 245 compliments.

People and those important to them could raise concerns and complaints easily, and staff supported them to do so.

Staff were committed to supporting people to provide feedback so they could ensure the service worked well for them.

People, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in areas used by people.

Staff protected people who raised concerns or complaints from discrimination and harassment. Staff knew how to acknowledge complaints, and people received feedback from managers after the investigation into their complaint.

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. Managers shared feedback from complaints with staff, and learning was used to improve the service.

Are Wards for people with learning disabilities or autism well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles and had a clear understanding of people's needs and oversight of the services they managed. Management and staff put people's needs and wishes at the heart of everything they did.

Leaders worked hard to instil a culture of care in which staff truly valued and promoted people's individuality, protected their rights and enabled them to develop and flourish.

Managers were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say.

Leaders and senior staff were alert to the culture in the service and as part of this spent time with staff/ people and family discussing behaviours and values.

Managers worked directly with people and led by example. The new ward manager was visible, approachable and staff felt well supported and confident with his leadership.

Good

Wards for people with learning disabilities or autism

Managers promoted equality and diversity in all aspects of running the service, staff and people using the service endorsed this.

Vision and strategy

Staff knew and understood the provider's vision and values and how to apply them in the work of their team.

The provider had a clear vision for the direction of the service that demonstrated ambition and a desire for people to achieve the best outcomes possible.

Managers set a culture that valued reflection, learning and improvement. They were receptive to challenge and welcomed fresh perspectives.

Culture

Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

The provider invested in staff by providing them with quality training to meet the needs of all people using the service.

The hospital had a peer support system in place for staff who had experienced a traumatic or potentially traumatic event in the workplace.

The hospital had a Multicultural Network Ambassador in post to support and co-ordinate multicultural activities within the service and provide a route for staff to seek support and raise concerns.

Staff felt able to raise concerns with managers without fear of what might happen as a result. Each ward had a designated Freedom to Speak Up Ambassador within their team.

Staff felt respected, supported and valued by senior staff, which supported a positive and improvement-driven culture. The hospital had implemented a staff wellbeing strategy.

Governance

Governance processes were effective and helped to hold staff to account, kept people safe, protected their rights and provided good quality care and support.

The provider kept up to date with national policy to inform improvements to the service.

Staff used recognised audit and improvement tools to good effect, which resulted in people achieving good outcomes.

Staff carried out clinical audit, benchmarking and quality improvement work to understand and improve the quality and effectiveness of care.

The management of records and recordings of surveillance ensured they were protected and stored safely.

There was a clear, recorded purpose for the use of surveillance supported by relevant assessment.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff were committed to reviewing people's care and support continually to ensure it remained appropriate as people's needs and wishes changed.

Senior staff understood and demonstrated compliance with regulatory and legislative requirements.

Staff were able to explain their role in respect of individual people without having to refer to documentation. They gave good quality support consistently.

Staff acted in line with best practice, policies and procedures. They understood the importance of quality assurance in maintaining good standards.

Information management

Staff collected and analysed data about outcomes and performance and engaged in local and national quality improvement activities. The manager provided good evidence of audits they were undertaking and reviewing.

Engagement

People and those important to them worked with managers and staff to develop and improve the service.

The hospital ran a regular staff relations group meeting, which gave staff the opportunity to raise concerns and share ideas.

Staff encouraged people to be involved in the development of the service.

The hospital ran a People's Council to ensure the voices of the service user and their carers were heard. A volunteer from the Council attended the clinical governance meetings to share feedback.

The provider sought feedback from people and those important to them and used the feedback to develop the service.

The service held formal listening events for family and friends to share their views and discuss issues with staff. The service used comments to improve the service.

The service worked well in partnership with advocacy organisations/ other health and social care organisations, which helped to give people using the service a voice/ improve their health and life outcomes.

Managers engaged with other local health and social care providers and participated in the work of the local transforming care partnership.

Good

Wards for people with learning disabilities or autism

Staff engaged in local and national quality improvement activities.

Learning, continuous improvement and innovation

The provider kept up to date with national policy to inform improvements to the service.

The provider invested sufficiently in the service, embracing change and delivering improvements.

The hospital Medical Director was awarded Medical Leader of the Year 2021 in the Cygnet Health Care National Psychiatrists Conference and Awards.

The provider had a clear vision for the direction of the service which demonstrated ambition and a desire for people to achieve the best outcomes possible.

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

Our rating of safe improved. We rated it as 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

At our last inspection in December 2019, we found that Sycamore ward had potential environmental risks such as blind spots which compromised patient safety on the ward. Since the last inspection the provider had separated Sycamore ward into Sycamore 1 and Sycamore 2. Staff could now observe patients in all parts of the wards. The provider had also installed convex mirrors, closed-circuit television cameras and ensure staff were positioned so they could easily observe patients to help manage risks.

Staff completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. Staff undertook regular risk assessments of the environment. A staff member carried out environmental checks of the ward during the day. This included any ligature risks, broken items and unpleasant odours.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Ligature risk assessments were undertaken on both wards on an annual basis, which included an audit of blind spots. Action plans were in place for areas where risks were identified. Potential ligature points were identified and known by staff. All patients admitted to the wards had an assessment of potential risks, which considered the ward environment. Any risks identified were managed with the use of patient observation.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff were trained in the use of personal alarms, which were tested at regular intervals.

Maintenance, cleanliness and infection control

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

Good

At our last inspection in December 2019, we found that Sycamore ward had potential environmental risks where the ward were not clean and communal areas were dirty. At this inspection we observed the ward areas were clean, well maintained, well-furnished and fit for purpose. Cleaning records were up to date. We observed housekeeping staff on the wards following a checklist of cleaning tasks throughout their shift.

Staff adhered to infection control principles, including handwashing. There were posters above basins on effective handwashing techniques. Hand gel and soaps were available to staff, patients and visitors throughout the ward. All staff completed infection control training which was mandatory.

Clinic room and equipment

The clinic rooms on both wards had emergency medications which staff checked regularly. The clinic room had a medicines cupboard, medicines refrigerator and physical health monitoring equipment.

There was a controlled drugs cabinet which was locked and secure. All cupboards and the refrigerator were tidy, in order and kept locked. The resuscitation equipment was stored in a nearby staff office. The provider ensured all equipment was clean, well maintained and calibrated. Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment.

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

In the last three months before the inspection staffing vacancy were relatively high. Senior managers told us the hospital had recruited international nurses and were waiting for these nurses to start. In January 2022 there were five full time equivalent staff nurses for Sycamore 1 ward and three full time equivalent staff nurses for Sycamore 2 ward for the month of January. These had reduced at the time of our inspection and was three full time equivalent staff nurses for Sycamore 1 ward and one full time equivalent staff nurse for Sycamore 2 ward for the month of March. Managers told us the vacancies for support worker had also reduced from 12 full time equivalent support workers across Sycamore 1, 2 and Peacock ward for the month of January to 7.6 full time equivalent support workers across the three wards for the month of March.

Despite some staff vacancies across the wards, there were enough staff with the right skills to provide safe care. The provider used a staffing matrix to identify how many staff should be on duty. Where there was more than one patient requiring constant nursing observation and engagement support, additional staff were put in place. The ward manager could adjust staffing levels daily to take account of case mix and this was discussed at management level on weekdays. Senior managers told us the hospital had recruited international nurses and were waiting for these nurses to complete employment checks before starting.

Patients had access to staff when they needed. A member of staff was usually present on the ward for patients to access, particularly when requiring leave. There was also a nursing assistant in the main corridor who was available for patients to engage with.

Ward staff told us that patients' leave or ward activities were rarely cancelled and there were enough staff to carry out physical interventions safely if necessary. Patients had one-to-one time with key workers and this was recorded in care records.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. The wards had permanent psychiatrists and out of hours arrangements for psychiatry cover were in place. Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Most staff had received and were up to date with appropriate mandatory training. Overall, 98.20% of staff on Sycamore 1 had completed their mandatory training, or were assigned to complete it within a set period. Similarly, 98.10% of staff on Sycamore 2 had completed their training, with some assigned to complete it by a set date. Bank staff were provided with a corporate and ward-based induction as well.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff 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 and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

We reviewed seven care records on Sycamore 1 and 2. Staff used the provider's standard risk assessment tool. All patients had a comprehensive risk assessment and key risks were clearly highlighted. This was completed for each patient on admission, using a recognised tool, and reviewed regularly, including after any incident.

Positive risk management was evident in the risk management plans and risk management was conducted in collaboration with patients. Risk management plans were recovery orientated and recognised the positive aspects of the patient's presentation and motivation to change.

Management of patient risk

Staff were aware of and dealt with any specific risk issues, such as physical health issues. Potential patient risks were highlighted in handover meetings and discussed further at length during multidisciplinary meetings. Multidisciplinary meetings were held daily and attended by psychiatrists, the ward manager, registered nurses and members of the therapy team.

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

Good

Staff identified and responded to changing risks to, or posed by, patients. Incidents involving patients were discussed at multidisciplinary meetings.

Staff followed policies and procedures for the use of observation, including to minimise risk, potential ligature points and for searching patients' bedrooms. Staff reviewed and documented patients' observation levels frequently. A member of staff was allocated to carry out regular observations throughout the day.

Patients were informed of any restricted or banned items, and a list of these items could be viewed on the ward. There were no inappropriate blanket restrictions in use on the wards at the time of our visit. Restrictions were only applied when justified based on individual patient risk and patients were given the rationale behind it.

Informal patients could leave at will and knew that. Most patients on the wards were informal. We found notices around the ward which detailed informal patients' rights.

Use of restrictive interventions

The provider regularly reviewed restrictive practices. If restrictions applied to individual patients these were included in the patient's care plan.

There was no use of long-term segregation or seclusion on the wards. Restraint was rarely used and only as a last resort. There were 16 incidents of restraint in the previous three months on Sycamore 1 ward. We were told there was a significant increase in number of restraints through March due to one patient requiring restraint to administer medication. Four of these incidents involved prone restraint. Staff received training on the management of violence and aggression, the use of restraint and de-escalation techniques. A policy on the management of violence and aggression was in place to support staff. Where appropriate, staff understood and worked with the Mental Capacity Act definition of restraint.

Incidents involving restraint were monitored across the service and disseminated and discussed within the governance structure of the hospital. There were no incidents involving the use of rapid tranquilisation in the previous three months.

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.

The staff we spoke with were confident about how to recognise and report safeguarding concerns. Staff undertook training in safeguarding adults at risk, with all having completed or been assigned to attend the training across both wards. Staff gave examples of when they had identified and raised safeguarding issues. The hospital had a lead for safeguarding who acted as the main point of contact between the wards and the local authority safeguarding team. Staff recorded safeguarding activity in patient care records and discussed current issues at multidisciplinary and team meetings.

The safeguarding lead maintained a log of safeguarding concerns raised with the local authority safeguarding team to monitor the progress and outcome of investigations. Patients had access to family visiting rooms off the ward where they could meet with visitors.

There were child visiting arrangements in place with safeguarding checks, and contact with children for patients whilst on leave.

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.

All staff had access to information needed to deliver patient care. Patient records were electronically and paper records. Bank and agency staff had access to this system and could add to the notes when required.

The information could be viewed by staff across the hospital to ensure effective and timely communication.

Information governance procedures guided staff to ensure patient information was handled correctly and protected from unauthorised access, loss, damage and destruction.

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 good practice in medicines management which was in line with national guidance.

This included storage, dispensing, reconciliation and recording of medicines information.

Medicines were stored securely and were only accessible to authorised staff. There were appropriate arrangements for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

Medicines requiring refrigeration were stored appropriately and safely. Staff monitored the temperatures of clinic rooms and medicines refrigerators. This ensured medicines were stored at the correct temperature and were effective.

Staff completed prescription records fully and accurately and medicines were prescribed in accordance with the consent to treatment provisions of the Mental Health Act. We saw there was a care plan in place and this listed the interventions staff should use before 'as required' medicines were used.

Staff reviewed the effects of medication on patients' physical health regularly and in line with NICE guidance such psychosis and schizophrenia in adults: recognition and management, especially when the patient was prescribed a high dose antipsychotic medicine.

We looked at 19 patients' prescription records. All the records had been completed correctly, were clearly written and had prescribing that was within accepted practice. A pharmacist provided oversight and regular audit. Ward staff and clinicians told us about the comprehensive support provided by the external pharmacy company, which included a weekly visit to the wards. The pharmacist highlighted any discrepancies in the management of medicines. These were monitored centrally to ensure compliance.

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

Good

Patients had access to pharmacy support to provide information about their medicines and any changes in their medicine prescribing.

Track record on safety

The service had a good track record on safety.

The ward manager informed us that there had been low number of serious incidents in the last three months. The provider's threshold for determining if an incident was a serious incident was low which meant that virtually all incidents were thoroughly investigated.

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.

All staff knew what incidents to report and followed the provider's policy. Staff reported incidents using an electronic system, which alerted managers when incident reports were submitted. Incidents were reported appropriately, and serious incidents had been notified to CQC and other agencies, for example, the local authorities and Health and Safety Executive, where appropriate.

Alerts about lessons learnt were shared with staff at handovers, team meeting. This included findings from other Cygnet hospitals. Staff could identify actions taken following incidents to prevent recurrence. For example, staff described how they had changed the process for ensuring that patients were physically well on admission. This was following a serious incident in which a patient passed due to poor physical health monitoring on admission and discharge on another ward.

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

Good

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

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

We reviewed seven patient care records and all patients had comprehensive and timely assessments completed following admission to the hospital. This included information relating to the reasons for admission and any previous mental health history if known.

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

Good

A physical health examination had been carried out for all patients as part of the admission process. Staff treated and monitored patients with ongoing physical health care needs. All patients received physical health checks on a weekly basis. The provider had implemented a new system to track the time in which newly admitted patients were first seen by a doctor. This was monitored by the clinical manager on a monthly basis.

All patients had fully completed, individualised and up-to-date care plans that contained their views. All care plans were holistic and recovery orientated. The electronic record system indicated that patients had been offered a copy of their care plan. Patients confirmed they were involved in care planning and a copy had been offered to them.

Patients' care plans were reviewed on a weekly basis to assess whether progress had been made towards objectives agreed at admission

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 provided a wide range of care and treatment interventions suitable for the patient group and as recommended by National Institute for Health and Care Excellence (NICE) psychosis and schizophrenia in adults. This included medicines and psychological therapies. Dialectic behavioural therapy and cognitive behavioural therapy were available for patients.

Patients had access to physical healthcare, including specialists when needed such as podiatrists, dentists and opticians. A speciality grade doctor assessed the physical health of patients during the admission process. All patients care records demonstrated their physical health was reviewed and monitored as part of their ongoing treatment.

Staff supported patients to live healthier lives. Patients were supported with healthy eating advice, this was supported by the Occupational therapy staff. For example, staff ran a weekly smoothie make session, this included providing awareness of five a day fruits and vegetable consumptions. Staff also promoted smoking cessation and nicotine replacement.

Staff used the Health of the Nation Outcome Scales rating scales (HoNOS) to assess the progress and outcomes of patients.

Clinical audits were used within the service to monitor care being provided, Staff completed audits on care plans, risk management plans, infection control, prescription charts, clinic rooms and equipment.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with 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.

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

Good

The acute inpatient wards teams included, or had access to, a range of professionals to meet the needs of patients. The multidisciplinary team comprised of consultant psychiatrists, nurses, support workers, occupational therapists and psychologist therapists.

Managers provided staff with an appropriate induction together with a programme of mandatory training both face to face and online. Staff were experienced and qualified to work within the service. Specialist training was available to staff, in addition to mandatory training, which was relevant to their posts. The hospital delivered in house specialist training sessions run by a variety of staff to meet identified learning needs and to implement lessons learnt. Training included physical health training and was planned for all staff across the hospital.

Managers provided staff with regular clinical and managerial supervision. Staff had access to supervision from a supervisor. They told us they found both forms of supervision to be supportive and helpful in reflecting on complex cases of patient care. From January 2022 to March 2022, 76% of staff on Sycamore 1 had received supervision. On Sycamore 2 all staff had received supervision in January and February 2022. Staff informed us that they felt supported by their manager and felt able to raise concerns and issues informally. Both managers had an open door policy for staff and patients.

Staff on both wards had annual appraisals of their work performance; 81% of staff on Sycamore 1 and all staff on Sycamore 2 had received an annual appraisal in the last 12 months. Managers ensured that staff had access to regular team meetings. These were held on a weekly basis and the minutes showed that there was a standing agenda to ensure that actions were followed up.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers dealt with poor staff performance promptly and effectively. Managers informed us they had support from their central human resources department and senior management team concerning action to address staff performance.

Multi-disciplinary and interagency team work

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

Ward staff operated as a multidisciplinary team framework and we observed a strong collaborative approach to care and treatment. Multidisciplinary meetings took place on a weekly basis. Each meeting was attended by the consultant psychiatrist, ward doctor, named nurse or nurse in charge, therapy team members, the patient and relatives or carers if appropriate. Advocates could be invited if patients requested their presence.

Handover records on both wards were detailed and included patient presentation, medicines, physical observations and observed risks. The wards had a nursing handover at every shift change, and a second handover each morning which was attended by the consultant, doctor and a member from the therapy team.

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.

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

Good

Mental Health Act (MHA) awareness training had been completed and was up to date for all for staff on both wards. We found that staff had a good understanding of the MHA, the code of practice and guiding principles. The hospital had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

At the time of our inspection, most of the patients on Sycamore ward 1 and 2 were being detained under the MHA. Their MHA paperwork had been completed correctly and was up to date. The hospital had a system to prompt staff to explain to patients their rights under the MHA. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff had access to administrative support and legal advice on implementation of the MHA. There was a dedicated MHA administrator who also completed a system of audits to ensure the MHA was being applied correctly.

Where required, patients had regular access to an independent mental health advocate who visited the ward upon request. Patients were offered the support of independent mental health advocates or automatically referred if they lacked capacity. Staff were aware of how to refer to independent mental health advocates and there was information about advocacy services in patient areas.

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.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

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.

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.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training had been completed and was up to date for all of staff across both wards. Staff had a good understanding of the MCA and the five statutory principles.

The provider had a policy on the MCA and staff confirmed they were aware of and had access to it. Should staff require further advice they contacted the MHA office which was on site. Staff gave patients every possible assistance to make a

specific decision for themselves. Staff completed and recorded mental capacity assessments for all patients upon admission. However, in the patients` record we looked at it was difficult to identify the mental capacity assessment. Some records showed that capacity was assessed and documented as "insight" whilst other records show "patient had capacity" and these were recorded in different parts of the record keeping tool the hospital used.

There had been no concerns raised regarding capacity or decision making for patients currently at the service. Staff told us that in the event of impaired capacity, they would make a decision in the best interests of patients, recognising the importance of the person's wishes, feelings, culture and history.

The service had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and acted on any learning that resulted from it.

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

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

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

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

Staff attitudes and behaviours when interacting with patients showed that they were positive, calm, respectful and responsive to the needs of patients. Staff knew patients well and provided the right kind of support based on their individual needs. Staff provided patients with help, emotional support and advice at the time they needed it.

We spoke with four patients. The feedback we received from patients was positive. Patients said that their thoughts and views were actively sought, considered and addressed. Patients described staff as approachable, polite, kind and helpful.

Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Upon admission, staff discussed patients' cultural, religious and social needs and documented these to provide effective care. They also helped patients access different services such as advocacy and specialist health services.

Patients said they felt able to raise concerns and that staff worked to resolve the issue quickly. Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour towards patients without fear of the consequences as there was an open culture.

Staff maintained the confidentiality of information about patients. Patient care records clearly documented patient preferences regarding the sharing of information with others. This information was securely stored online.

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 used the admission process to welcome patients to the ward and introduce them to the service. Patients were involved in the planning and review of their own care and treatment, with an input in their care plans and risk assessments. We reviewed seven care records. Staff recorded changes in the patient's personal needs or preferences. All patients had been offered a copy of their care plan.

On both Sycamore 1 and 2 ward, patients were given an information leaflets upon admission which detailed the facilities, treatment options, therapeutic input, safeguarding concerns, complaints process, advocacy, restaurant and food access, and avenues for giving feedback about the ward.

Patients were given opportunities to voice their opinions in multidisciplinary reviews and this was recorded in the patient's care record. Patients were also able to give feedback about the service through community meetings, complaint and comment boxes. Patients met with their consultant psychiatrist once a week. They also had a weekly one-to-one meeting with their primary nurse each week to discuss their care plans and recovery goals.

The wards held community meetings for patients to discuss issues about the ward. Patients had access to a named nurse whose role was to develop support plans personalised to their individual needs. Patients met with staff at community meetings each week. During these meetings patients gave feedback on food, the environment, activities and other matters. Patients could also raise concerns during one-to-one sessions with nurses or through the complaints procedure.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Some leaflets could be procured in easy-read versions to accommodate patients with learning disabilities.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff told us they informed and involved families where consent was gained from patients and provided them with support when needed. Families and carers were given an information leaflet explaining visiting times and ward rounds. Staff told us carers were invited to ward round meetings and were encouraged to keep up to date with patients' progress by speaking with nursing staff. The wards held a carer's conference in late 2021

Three of the four carers we spoke with told us they supported, informed and involved families or carers in most cases. One carer told us that all the staff on the wards were friendly and that their relative knew every member of staff working on the ward. However, one carer told us they did not feel included their relatives care and treatment. For example, they said they had not been given any information about why their relative had been admitted, what their diagnosis was or what medication was prescribed and why. Carers that we spoke to expressed their frustration with contacting the wards via telephone regarding visit access during Covid-19 outbreaks at the hospital. Carers told us that it could sometimes take multiple phone calls in one day to get through to ward staff and get conflicting messages regarding visit access.

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

Good

Carers could provide feedback to the service through direct contact with staff. Support and advice was available for carers including written information on how to access support.

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

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Most of the beds in the acute service commissioned by local NHS trusts and most patients were from the South West area. The service also accepted referrals from across the UK.. The wards had specific admission criteria which described the characteristics of patients who would be offered admission to the hospital. The hospital did not admit patients whose acuity levels could not be safely managed on the wards.

All patients had access to a bed on return from leave as the service did not use the beds in the absence of patients on leave. Patients were transferred to other hospitals within the area if their risks became unmanageable within the service. The team were usually able to locate an available bed in a psychiatric intensive care unit (PICU) if a patient required more intensive care.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. When patients were moved or discharged, this happened at an appropriate time of day.

Discharge and transfers of care

We reviewed seven care records and they all contained evidence of discharge planning for patients. Staff told us they planned for patients' discharge from the point of admission. Where patients had consented, staff also involved carers and family members in discharge plans. Discharge plans helped to ensure smooth coordination of services and care after a patient left hospital. Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Patients did not have to stay in hospital when they were well enough to leave.

Staff supported patients during referrals and transfers between services – for example, if they required treatment in emergency services or a psychiatric intensive care unit.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

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

Good

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.

All patients had their own bedrooms with ensuite facilities. Patients could personalise their bedrooms and we saw that some patients had brought family photographs and posters to decorate their rooms. Most patients chose not to personalise their room due to the short-term nature of their stay. Both wards had a separate clinic room for physical examination and care.

Patients had somewhere secure to store their belongings. All patients had a safe in their rooms for personal items of value. Restricted items were stored in a patient possessions cupboard, which could only be accessed under staff supervision. Patients could keep their mobile phone based on individual risk assessments and could also access a ward phone to make personal calls. Patients could access the outdoor area and there were gardens for patients to relax in.

Patients had access to hot drinks and snacks at all times, and there was an automatic hot beverage machine for patient use. There was fresh fruit available in the common area and lounges. Patients could also access the on-site restaurant during the day for other food and refreshments. The service offered a variety of good quality food.

An active life co-ordinator was employed by the hospital to provide supervision and guided sessions in physical exercise, for example, swimming, tai chi, yoga and boxercise at the local gymnasium.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients' engagement with the wider community

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

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the service and in the wider community. The service appointed an active co-ordinator how facilitated psychical activities at the hospital and in the community. This included taking patients to the local gymnasium and swimming pool.

Staff made sure patients had access to opportunities for education and work, and supported 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 made adjustment for people with mobility issues. Disability access for people who used wheelchairs was available on the first floor.

There was a lift for people requiring wheelchair access support on the wards. Information for patients was posted on notice boards to ensure patients could obtain information on the complaints process, advocacy, local mental health and physical health services, healthy eating and medicines information.

Managers informed us that leaflets could be obtained indifferent languages from the provider's central network and knew how to access interpreters and/or signers.

A range of food was available for patients to meet their dietary needs. Patient feedback was sought on the range and quality of food provided. Catering staff were invited to the community meeting to receive and respond to patient feedback regarding food.

Spiritual support was available for patients and staff liaised with local religious organisations to provide support based on patients' individual needs. There was a faith room on site for patient use.

The hospital had held a number of recent events, including an International Mother Language Day run by the multicultural network ambassador. Staff and patients also worked together to plan and run a Christmas Fayre.

Patients had access to a range of therapy options Monday to Saturday from 9am to 5pm. This included art psychotherapy, self-esteem building, creative expression, mood and food, family therapy, poetry and transactional analysis. There were also a few therapies aimed at maintaining better relationships, emotional resilience and with a focus on relaxation, such as aromatherapy and mindfulness.

However, since patients were engaged in an intense therapy programme, they did not feel that the lack of other activities had much impact on their treatment and recovery. We spoke with four patients who told us they enjoyed having time to relax in the evenings and on Sundays.

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 were given information about how to make complaints by staff and the process was also described on the ward notice board.

The hospital held daily reflection meetings, and weekly community meetings. Patients were encouraged to raise any issues, compliments and complaints during these meetings. We saw that these were responded to with the outcomes shared at the next meeting and displayed on the ward noticeboards. The ward notice boards on both wards displayed the 'we listen, we respond, we improve' posters which detailed improvements the hospital had made resulting out of patient or carer feedback.

Staff understood their role in helping patients raise concerns or complaints, and protected patients from discrimination and harassment. The managers knew the hospital's policy in managing complaints. We viewed completed investigations and complaint responses which demonstrated accountability and transparency. People who complained received a full written response and were given information on the next stage if they were unhappy with the response received.

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

Good

On the acute wards, in the last 12 months there had been 58 complaints out of which 18 were informal complaints and 40 were formal complaints. 28 complaints were resolved within 20 days, eight complaints were closed but not resolved within 20 days .The remaining complaints had been withdrawn or were under investigation at the time of the inspection.

Staff received feedback on complaints and common themes were shared across all wards so that improvements could be made.

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

Good

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Since the inspection in December 2019, there had been changes in the senior management of the hospital and some ward manager posts. Apart from the medical director, the senior management team were relatively new to their posts. However, they had extensive clinical and managerial experience. In a short space of time, they had made a demonstrable impact to the safety and quality of care provided to patients.

The senior managers and ward managers had a very good understanding of the services and their challenges. They knew how staff worked to provide high quality care. The senior management team were visible and accessible to staff and patients. They demonstrated effective leadership skills, were role models, and had developed an inclusive culture. They empowered staff to develop ideas to improve the care of patients.

Both ward managers had a good understanding of the services they managed and a clear focus on providing high quality care. Staff were positive about their managers and felt well supported and listened to. Staff said the managers had an 'open door' policy, were very visible on the wards and helped support staff on the wards in practical ways. All staff felt comfortable raising issues directly with senior colleagues and were confident these would be addressed.

Leadership development opportunities were available and staff were encouraged to develop skills and competencies. There were also opportunities for below this level to develop.

The ward managers knew the training and development needs of the staff, and supported staff to attend training to develop skills and competencies. For example, support workers were encouraged to pursue training in health and social care level four. The support workers who took up this opportunity spoke positively of the experience and their learning.

Vision and strategy

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

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

Good

Staff knew the visions and values of the organisation and felt that these were reflected by their team and the service they provided. Managers ensured team objectives reflected those of the organisation through team meetings, supervision and appraisals. There were displays communicating what the values were on ward notice boards and further information was available on the provider's intranet.

Staff knew who senior managers were at the hospital and felt they were approachable and supportive. Other senior executives from outside the hospital had recently visited the service and they were known to staff.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Policies had been reviewed and updated by the provider and staff were included in this process.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff we spoke with talked positively about their roles and were passionate about the service developing. Staff felt able to raise concerns without fear of victimisation and spoke positively about the organisation. Staff members at all levels told us they felt valued, had input into the service, and were consulted and involved in service quality development. The hospital had implemented a staff wellbeing strategy.

The hospital had a peer support system in place for staff who had experienced a traumatic or potentially traumatic event in the workplace.

The hospital had a Multicultural Network Ambassador in post to support and co-ordinate multicultural activities within the service and provide a route for staff to seek support and raise concerns.

Staff were aware of the provider's whistleblowing policy and the role of the speak up guardian. Each ward had a designated Freedom to Speak Up Ambassador within their team. Staff knew how to use the whistleblowing process. However, all staff we spoke to said they would raise concerns directly with management and described the culture as being very open and honest. They felt confident that their concerns would be acted upon without recourse to the whistleblowing procedure.

During our last inspection in December 2019 we saw that staff performance were not managed effectively. However, during this inspection the ward managers felt comfortable with managing staff performance, including where disciplinary actions may be needed. Teams worked well together and where there were difficulties the managers dealt with them appropriately. Managers had support from the human resources department, senior management and external supervisors for guidance.

When we spoke with staff, most informed us that there were some opportunities for professional and personal development at the hospital. They felt able to talk about training opportunities with their managers, and some had progressed into different roles over time. Annual appraisals included conversations about career development and how it could be supported. However, sometimes due to budget and time constraints, not all opportunities could be taken up.

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

Good

The provider promoted equality and diversity in the workplace and patient care. All staff received training on the Equality Act 2010. Some discussions at patient community meetings and staff reflective practice were focused to assess patient and staff satisfaction with a broad range of issues, including equality and diversity.

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.

During our last inspection in December 2019 we saw there was a lack of robust governance system in place at the hospital to over the acute mental health inpatients wards. However, during this inspection, we saw the provider had made improvement. There was a clear governance structure in place with routes of escalation, reporting and decision making. Ward managers and the senior management team had access to a dashboard relating to the quality and safety of the care delivered. There were clear agendas in place for what must be discussed at a ward, team or hospital level meeting to ensure consistency and following up on outstanding actions.

The provider had monthly governance, learning and outcomes group meetings which reviewed incidents, complaints and learning actions. This was agreed and monitored by hospital managers. Essential information, such as learning from incidents and complaints was shared.

In addition, there were also monthly health and safety meetings, clinical governance meetings and weekly senior management meetings. The minutes from the clinical governance meetings were accessible to staff and sent out by email. This included feedback regarding estates issues and quality improvement.

Staff implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. There was an enhanced pre-admission screening tool concerning potential patient risks. This had been introduced following a serious incident.

Staff undertook clinical audits and used these to gain assurance about the services provided. Staff acted on the results when needed and the hospitals' performance was reviewed and benchmarked against local and national outcome measures. There were monthly and annual audit schedules in place which included the environment, care records, health and safety, clinic room, medicines management and Mental Health Act documentation.

Managers had set up "you said, we did" notice boards across all the wards. We witnessed a co-production group which met monthly with patients and staff representatives from across the hospital and which contributed to these notice boards.

Whilst the vacancies for all staff remained relatively high, managers had implemented a proactive international recruitment strategy. They held monthly open days for local people to access vacancies and see the hospital.

There was an effective system in place to ensure all staff received appropriate levels of mandatory training and that this training was kept up to date. There was a central electronic mandatory training compliance system that managers could access and maintain oversight of training needs.

The service had access to a pool of bank staff that could cover shifts within the service. Agency staff were also employed to cover some nursing shifts. Managers endeavoured to use regular bank and agency staff wherever possible.

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

Good

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. For example, staff had good relations with local social service providers, and care coordinators to ensure smooth discharge processes for patients.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

There was a system in place to identify, monitor and address risks at the hospital. Staff maintained and had access to the risk register at ward level. Ward managers could escalate concerns when required. There was an up to date risk register in place for the hospital and the risks listed were discussed at the clinical governance meeting. This ensured that risks were continually monitored and minimised where possible.

The hospital had contingency plans in place for major incidents and unforeseen circumstances which could affect the running of the service.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff had access to the equipment and information technology needed to do their work. The technological infrastructure worked well and enabled them to record and review information they needed to provide good treatment and care.

Team managers had access to key information to support them with their management role. The service used systems to collect data from wards that were not overly difficult for staff .Information governance training was mandatory for all staff directly employed by the hospital, and this included maintaining confidentiality of patient records. Staff made notifications to external bodies as needed, such as CQC and Health and Safety Executive notifications.

Engagement

Managers engaged actively 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.

Staff, patients and carers had access to up to date information about the work of the provider and the services they used. For example, they updated the ward notice boards whenever information was out of date, and we saw evidence of this happening. Staff were provided with regular updates in handover, team meetings, supervision and the intranet. The hospital ran a regular staff relations group meeting, which gave staff the opportunity to raise concerns and share ideas.

Patients and carers had opportunities to give feedback on the service they received. They could do this through direct contact with staff, comment boxes and community meetings. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. Minutes from these meetings were used to ensure that requests from last meeting had been met.

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

Good

The hospital ran a People's Council to ensure the voices of the service user and their carers were heard. A volunteer from the Council attended the clinical governance meetings to share feedback.

Patients and carers were involved in decision making about changes to the service. Due to the short stay nature of patients, there were not always opportunities for them to get involved. Senior managers regularly engaged with staff through quality walk arounds. Staff told us that senior managers were very visible and approachable. The hospital manager and senior management had good relationships with external stakeholders, such as the local authority and local NHS trusts.

Learning, continuous improvement and innovation

The clinical team undertook a quality improvement project, focussed on implementation of calm cards. Calm cards are a resource aimed at lowering usage of medicines.

The hospital Medical Director was awarded Medical Leader of the Year 2021 in the Cygnet Health Care National Psychiatrists Conference and Awards.

The hospital submitted a quality improvement project to test the effects of positive behavioural support (PBS) training on managing behaviours that challenge to the Royal College of Psychiatrists. This was accepted for display at their annual conference.

Good

Wards for older people with mental health problems

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

Are Wards for older people with mental health problems safe?

Good

Our rating of safe stayed the same. We rated it as 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 ward areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the ward. The ward had mirrors to ensure clear lines of sight in all areas. Bedroom doors had vistomatic windows that could be operated by patients or staff.

The ward complied with national guidance and there was no mixed sex accommodation. At the time of the inspection there were both male and female patients on the ward following the recent closure of the separate all male ward and all female wards. Patients all had their own ensuite bedrooms. Female patients had a separate lounge which was well used. Male and female patients had bedrooms on separate corridors.

There were no potential ligature anchor points in the ward.

Staff had easy access to alarms and patients had easy access to nurse call systems. Patients had alarms in their rooms to summon staff if needed.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. The ward presented as cheerful, bright and well decorated.

Staff made sure cleaning records were up-to-date and the premises were clean. We reviewed a range of cleaning records and these were well maintained.

Staff followed infection control policy, including handwashing.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs.

Staff checked, maintained, and cleaned equipment. All equipment checks were completed weekly and were upto date. There was also weekly first aid box checks and nightly clinic room checks.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. The ward was almost fully staffed with permanent registered nurses and support workers with only one nurse and one support worker vacancy.

The service had low rates of agency nurses and agency nursing assistants. The use of bank staff was higher with one bank staff member on duty most days. This was short term until the vacancies were recruited into. The posts were due to be filled shortly. The manager requested bank and agency staff familiar with the service to ensure patients saw familiar faces.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Both bank and agency staff completed an induction which included information about the patients care and treatment, orientation to the ward and policies and procedures to protect patients.

The service had low turnover rates with only two staff members leaving last year. The manager said the staff tended to stay on the ward as it was a happy ward to work in.

Managers supported staff who needed time off for ill health. Levels of sickness were low at around 2%.

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. Staffing levels were discussed at the daily service wide meetings to ensure each ward had enough staff.

Patients had regular one-to-one sessions with their named nurse. This was documented in each patients' care record.

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.

Good

Wards for older people with mental health problems

Staff shared key information to keep patients safe when handing over their care to others.

Handovers were recorded and staff were given sufficient time to meet together and discuss each patient

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. There were two doctors and a consultant on the ward.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Staff completion of mandatory training was high at around 98%.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Each ward had a weekly operations meeting that monitored the staff completion of mandatory 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 and seclusion 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 using a recognised tool, and reviewed this regularly, including after any incident. In all files reviewed the risk assessments were completed upon admission and regularly updated during the patients stay. Any changes to risk were included in the assessment. The manager monitored completion of updated risk assessments to reflect patients' current risk.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Risk management for example, about the likelihood of falls was well documented. Risk management was discussed at staff handover, operational meetings, multi-disciplinary meetings and the wider daily operational meeting.

Staff identified and responded to any changes in risks to, or posed by, patients. Risk assessments were updated if there were any incidents or changes in patients' presentation. Staff could observe patients in all areas of the wards.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low. Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

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. The use of restraint was a last resort. They avoided use of restraint by techniques like verbal de-escalation. This meant restraint was staff ushering or redirecting a patient in a different direction as opposed to the use of hands on holds. The hospital did not practice face down restraint, sometimes called prone restraint.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. There were no incidents of rapid tranquilisation on the ward in the last year.

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. They kept up-to-date with their safeguarding training. All staff were up-to-date with their safeguarding training. This was carefully monitored by the manager and operation leads.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. There was one safeguarding referral last year. The manager worked closely with the services safeguarding lead to make a referral to the local authority using a decision making tool provided by the local authority. The safeguarding lead for the hospital kept a log of all incidents considered for safeguarding referral and the outcome of these. Safeguarding issues were discussed in the daily service wide situational meeting.

Staff followed clear procedures to keep children visiting the ward safe. There was a separate room off the ward for any visits. All visits had to be booked. Staff supported patients to develop care plans if they needed to be supervised.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff spoken with demonstrated a good understanding of the services safeguarding policies and procedures.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Good

Wards for older people with mental health problems

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. They were stored securely on an electronic system.

When patients transferred to a new team, there were no delays in staff accessing their records.

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.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. They completed medicines records accurately and kept them up to date.

Staff followed national best 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.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Any side effects were clearly documented in patients' files.

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. There were 40 recorded incidents on the ward this year. This represented a significant reduction of incidents from the previous year. For example, in January 2021 there were 81 incidents. However, by January 2022 there were only seven. Similarly, in March 2021 there were 24 **i**ncidents but in March 2022 there were only 13 Incidents.

Staff said the reduction was due to the new manager's input. The manager said the mixing of the male and female wards contributed to the reduction in incidents amongst the men. She noticed there were fewer male incidents of violence and aggression in the mixed ward.

Good

Wards for older people with mental health problems

Staff raised concerns and reported incidents and near misses in line with provider policy.

Staff understood the duty of candour and gave patients and families a full explanation if and when things went wrong.

Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service. There was a lesson learned folder on the ward which went back to incidents from 2020 on both this ward and across the service.

There was evidence that changes had been made as a result of feedback. For example, there have been recent changes in how staff gathered information about patients and changes to discharge documentation.

Staff met to discuss the feedback and look at improvements to patient care.

Managers debriefed and supported staff after any serious incident.

Are Wards for older people with mental health problems effective?

Good

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. These were fully documented in all files reviewed.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Care plans were in place for patients diagnosed with physical health needs like diabetes. Patients' health checks by the medical team included skincare, falls assessments, Malnutrition Universal Screening Tool (MUST) and vital signs. Alongside the physical health checks by the doctors and consultants the manger had stated a physical health check clinic each Friday. It was nurse led. Patients were encouraged to bring any health concerns they had.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. The managers stated that the team had worked hard to redesign their care planning into an easy read format.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Good

Wards for older people with mental health problems

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.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance from relevant bodies. Staff members followed National Institute for Clinical Excellence (NICE) guidelines in relation to anti-psychotic medication monitoring. There was detailed physical health monitoring for side effects and psychological therapies were promoted alongside medical regimes.

Staff identified patients' physical health needs and recorded them in their care plans. They made sure patients had access to physical health care, including specialists as required. Staff had made external referrals to physiotherapy via a local GP who visited weekly.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Patients' hydration and nutrient intake was routinely monitored with nutrition and hydration charts. These were regularly updated and reviewed.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Cooking for healthy eating was part of the activity programme on the ward.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The Health of The Nation Outcome Scale was completed for all patients at the point of admission to the service and reviewed routinely by staff thereafter. This is a measure of the health and social functioning of people with severe mental illness and contains 12 items measuring behaviour, impairment, symptoms and social functioning.

Staff used technology to support patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. These included care records, safeguarding, complaints and incidents

Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). 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. This included consultants, doctors, occupational therapists, speech and language therapists, nurses, and support workers. Patients had access to a physiotherapist via the local GP.

Good

Wards for older people with mental health problems

Managers ensured staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff. The compliance manager and the manager were responsible for ensuring that agency staff had up to date training and the right skill set. The compliance manager was in the process of reviewing the system for obtaining photocopies of training qualifications for agency staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported permanent non-medical staff and medical to develop through yearly, constructive supervision and appraisals of their work. Virtually all staff had received regular supervision throughout the years.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. They made sure staff received any specialist training for their role. The hospital delivered in house specialist training sessions run by a variety of staff to meet identified learning needs and to implement lessons learnt.

Managers recognised poor performance, identify the reasons and deal with these.

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The managers made sure they shared clear information about patients and any changes in their care, including during handover meetings. Patients were discussed at the daily multi-disciplinary service wide meeting.

Staff had effective working relationships with staff in other wards in the service.

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.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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 demonstrated a good understanding of the different Sections under the Mental Health Act.

Good

Wards for older people with mental health problems

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

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. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Informal patients knew that they could leave the ward freely. There were signs around the ward explaining that inpatients could leave freely, although these were not always easily visible. This was discussed in the ward's admissions process with all patients.

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

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

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 were no Deprivation of Liberty Safeguards applications made in the last 12 months.

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.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We reviewed twelve capacity and consent forms in patient files. Six patients lacked capacity to consent and this was well documented. Four patients assessed as having capacity had signed their consent form and two patients assessed as not having capacity had yet signed the consent to treatment form. This was known to the staff and was in the process of being resolved.

Good

Wards for older people with mental health problems

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. Staff regularly attended best interests meeting and these were documented appropriately.

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

Are Wards for older people with mental health problems caring?

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. Staff responded quickly when patients required help and assistance. They were respectful when delivering personal care.

Staff gave patients help, emotional support and advice when they needed it. Patients were overwhelmingly positive about support they received. They spoke of kind staff who listened attentively and made them feel valued.

Staff supported patients to understand and manage their own care treatment or condition. Staff worked closely with patients to encourage independence whilst receiving treatment. For example, one patient cooked steaks for other patients at a dinner party. The manager said this reflected what they might do in their own home and this was the ethos of the ward.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. Patients gave many examples of staff getting to know and understand each patient and helping the develop their interests. For example, a patient used to paint oil paintings many years ago, the staff introduced them to acrylic paints, and they got them a canvas frame to paint on. This patient regularly paints now, and it has become part of their daily routine which contributed significantly to their wellbeing.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Patients raised concerns at the community meetings or in one to one meeting with staff,

Staff followed policy to keep patient information confidential.

Involvement in care

Good

Wards for older people with mental health problems

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. Patients received additional support and a variety of communication methods during admission to orientation them onto the ward.

Staff involved patients and gave them access to their care planning and risk assessments. Patients routinely attended care planning meetings and reviews. They were given a copy of care plans to ensure they understood and agreed to their care and treatment.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Staff involved patients in decisions about the service, when appropriate.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Patients regularly attended the weekly community meetings held on the ward to give feedback. They recently asked for more activities, so a table tennis set was purchased and trips to the hydro pool organised for patients.A patient told us that during their recent stay staff were discussing having the dining room redecorated and they asked for all the patients input for the colour scheme.

On the day of inspection, we used a symbol-based communication tool to talk with patients. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff or relatives and the person themselves. In this report, we used this communication tool with three people to tell us their experience. Patients were unanimously happy with the service they received. A patient spoke of being slightly disturbed by lighting during staff observations at night and the staff were working with them to address this.

Staff supported patients to make decisions on their care. Patients attended reviews and were included in their care plans.

Staff made sure patients could access advocacy services. Patients had access to independent mental health advocate (IMHA) and independent mental capacity advocate service (IMCA).

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Carers spoke positively about the support they received from the staff.

Carers said they had weekly a zoom calls with consultants. They would talk together then the patient joined in the call along with a member of staff who knew them well. They said they felt part of the discussions and involved with their relatives care even though they could not always physically meet up with them.

Good

Wards for older people with mental health problems

Some carers said they would have welcomed a call from staff on the first day/night to reassure them their relative had settled in.

Staff helped families to give feedback on the service. Six months ago, there was a weekly carers forum but over the last few months attendance dropped until it no longer operated. The manager had plans to restart this group.

Staff gave carers information on how to find the carer's assessment during the admission process.

Are Wards for older people with mental health problems responsive?

Good

Our rating of responsive improved. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers made sure bed occupancy did not go above 85%. There were 13 patients in the fifteen bedded ward on the day of inspection. The manager said there was usually between ten and 13 patients on the ward.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. This took place at the multi-disciplinary meetings, weekly operational meeting, and the daily situation meeting. Staff reviewed discharge pathways during these meetings and documented it within the minutes.

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 wards during their stay 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. Discharge plans included discussions with the patient, carers and relatives about the most convenient times for discharge.

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends. The hospital had arrangements with its local trust to access psychiatric intensive care units (PICU) if acutely unwell patients could not be managed on the ward. The service also had access to a local Hospital when patients required physical health support, treatment, and emergencies.

Discharge and transfers of care

Good

Wards for older people with mental health problems

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. There were few delayed discharges on the ward throughout the year as discharge planning started upon admission.

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

Staff did not always carefully plan patients' discharge and work with care managers and coordinators to make sure this went well. In 2019 a patient was discharged and travelled without the staff ensuring they had satisfied themselves the patient was fit to travel. This resulted in a serious incident. Following this incident, the service reviewed their discharge procedures to ensure patients were only discharged if a doctor had completed both a fit to be discharged and a fit to travel document.

In two of the last three patients' files who were recently discharged from the ward there was a fit to be discharged document but not a fit to travel document. There was no evidence in one file the patient had been physically seen by the discharging doctor. The managers and doctor said that the two patients were being discharged home, so the discharging doctor had not thought it necessary to complete the fit for travel document. Whilst both patients completed their journey safely, the senior managers and the doctor accepted they would benefit from a clear policy on discharge documentation to avoid ambiguity and ensure a consistent approach.

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.

Each patient had their own bedroom, which they could personalise. Staff members spent time finding out patients interests and if requested assisted them personalise their rooms to reflect these interests. For example, one patient liked dogs, so staff found pictures and prints to decorate their room. They also had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. The ward had quiet areas and a family room off the ward where patients could meet with visitors in private.

Patients could make phone calls in private. They had access to the ward phone, and they had their own mobiles when appropriate.

The service had large grounds that patients could access easily. There was also a closed courtyard. The occupational therapist was working with senior staff in the Hospital to make the space more accessible for patients.

Patients could make their own hot drinks and snacks and were not dependent on staff. Patients told us they could make their food and hot drinks at any time of day.

Good

Wards for older people with mental health problems

The service offered a variety of good quality food. All patients spoken with were happy about the quality of food provided on the ward.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. The manager assisted patient produce artwork for display.

Staff helped patients to stay in contact with families and carers. They used zoom calls if relatives were not able to visit to ensure patients stayed in touch.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. There were trips to local shops, bowling, the reptile zoo and garden centres.

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 could support and make adjustments for disabled people and those with communication needs or other specific needs. The manager worked closely with the occupational therapists and speech and language therapists to ensure there was a variety of communication aids and adaptions. There was easy read documentation and staff could communicate using Makaton which uses signs and symbols to support spoken language.

Staff made sure patients could access information on treatment, local service, their rights and how to complain was available on the ward.

The service was able to order information leaflets available in languages spoken by the patients and local community if they were requested by patients or carers.

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

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients were supported and encouraged to cook their own food. The staff had purchased a casserole slow cooker for patients to make stews. The ward menu was altered according to the needs and wants of the current patients. A vegetarian option was always available. The staff were imaginative about food. For example, they had 'eat the rainbow' themes where patients deliberately ate different coloured fruits and vegetables each day.

Patients had access to spiritual, religious and cultural support.

The hospital had held a number of recent events, including an International Mother Language Day run by the multicultural network ambassador. Staff and patients also worked together to plan and run a Christmas Fayre.

Listening to and learning from concerns and complaints

Good

Wards for older people with mental health problems

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.

The service displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. They knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes.

On the ward there were few complaints. There were only four complaints in the last year. One complaint was about missing medication upon discharge. This was upheld. The other complaints were made about communication and not being shown around the ward. These were investigated and partially upheld. None of the complaints went to the ombudsman.

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

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

Managers shared feedback from complaints with staff and learning was used to improve the service.

The managers said that the learning from the complaints was around better communication between staff and carers. They had developed room packs about what patients, the facilities and what they could expect to see in their rooms and on the ward.

The service used compliments to learn, celebrate success and improve the quality of care.

Are Wards for older people with mental health problems well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The manager had worked in the ward for a year and described it as their ideal place to work. She had previous experience of working on the ward prior to becoming the manager.

Staff members and patients were very positive about the way the wards were managed. They reported feeling valued, respected and supported.

Good

Wards for older people with mental health problems

The senior leadership team were visible and responsive.

Vision and strategy

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

The service had a vision for what it wanted to achieve. Staff knew and understood the services vision and values and how they were applied in the work of their ward.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

The manager promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. All staff spoken with placed the ward managers enthusiasm and positivity at the centre of the inclusive, open friendly culture on the ward.

Staff morale was good, and staff felt supported. They described the ward as a happy enjoyable place to work. The hospital had implemented a staff wellbeing strategy.

The hospital had a peer support system in place for staff who had experienced a traumatic or potentially traumatic event in the workplace.

The hospital had a Multicultural Network Ambassador in post to support and co-ordinate multicultural activities within the service and provide a route for staff to seek support and raise concerns.

There was an emphasis on development and staff were encouraged to engage in training and personal development opportunities. For example, support workers were encouraged to train as nursing associates and then train to become nurses.

Staff received praise and compliments from patients, family and carers. These were available on the ward and shared with staff across the service at the daily operational meeting.

All staff knew how to access the whistle blowing policy. They felt that they could raise any concerns with the managers without fear of retribution. Each ward had a designated Freedom to Speak Up Ambassador within their team.

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.

Good

Wards for older people with mental health problems

The ward had effective governance structures in place to monitor the safety of the environment, performance and risk. The manager took part in the daily service wide meeting. This was attended by consultants, ward managers, HR (Human Resources) and clinical managers. They discussed estates, patients care and treatment, risk management and Mental Health Act 1983 status of each patient.

The manager from the ward also attended monthly governance meetings which monitored safeguarding, absence management, incidents, lessons learned and medicines management. This information was discussed at the weekly team meetings and daily handovers.

Managers had set up "you said, we did" notice boards across all the wards. This was discussed at patient's community meetings and updated once patients' requests were completed.

The ward had an open culture to incident reporting that encouraged staff to report incidents.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The staff had access to the information they needed to provide safe and effective care and were able to identify shortfalls.

The management of risk was managed well both in the ward and within the wider service. It was prioritised at the service wide operation situational meeting, the weekly ward operations meting and staff meetings.

Information management

Staff engaged actively in local and national quality improvement activities.

Staff had access to the equipment and technology to do their work.

Information governance systems ensured confidentiality of patients records on the ward.

The ward manager had oversight and access to information that allowed them to run the ward safely and effectively. This included staff training, supervision and appraisal records and budgets.

The manager and staff team were working towards accreditation with the National Association of Psychiatric Care.

Engagement

Managers engaged actively 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.

Good

Wards for older people with mental health problems

The hospital manager and senior management had good relationships with external stakeholders and worked closely with the local authority and local NHS trusts. The local GP visited the ward weekly and worked closely with the staff on the ward.

The hospital ran a regular staff relations group meeting, which gave staff the opportunity to raise concerns and share ideas.

The hospital ran a People's Council to ensure the voices of the service user and their carers were heard. A volunteer from the Council attended the clinical governance meetings to share feedback.

Learning, continuous improvement and innovation

The ward was working towards accreditation with the National Association of Psychiatric Care. They had identified areas to develop like the peer review process with other similar services to ensure shared learning.

The hospital Medical Director was awarded Medical Leader of the Year 2021 in the Cygnet Health Care National Psychiatrists Conference and Awards.