Cygnet Churchill

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Churchill as good because:

- The service provided safe care. The ward environments were safe and clean. Juniper ward (an acute admissions ward) had recently been refurnished and was a suitable environment for its patient group. The wards had enough nurses and doctors to meet the needs of patients. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health high dependency rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- All the ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff 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.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. There were some instances of delayed discharges due to challenges in finding suitable placements in the community, but staff worked well with external organisations in the patients' local area to solve this.
- The service worked to a recognised model of mental health rehabilitation. It was well led and the governance processes ensured that ward procedures ran smoothly and that patients were discharged to local community services or their home, within a reasonable timeframe.

However:

- At the time of the inspection, the provider did not stock emergency Naloxone medicine despite admitting patients who presented with risks for illicit opiate and substance misuse. The provider had since sourced and stocked emergency Naloxone medicine.
- Staff on Maple Court did not always meet their responsibilities under the Mental Health Act 1983 Code of Practice. For example, ensuring a manager's review hearing took place before the expiry of a patient's section and having clear records of whether a patients' nearest relative was informed of their detention under the Mental Health Act.
- Staff did not make notifications to external bodies as needed. For example, between 01 January 2019 and 29 October 2019 we found 17 incidents of allegations of abuse in relation to service users that were not reported to the Care Quality Commission.

Summary of findings

Contents

Good

Cygnet Churchill

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Long stay or rehabilitation mental health wards for working-age adults.

Summary of this inspection

Background to Cygnet Churchill

Cygnet Churchill was previously run by the Cambian Group and came into the ownership of Cygnet Health Care in May 2018.

Cygnet Churchill is an independent hospital providing mental healthcare for adult males. The service is divided into four wards:

Juniper ward – a 17-bed acute ward for men. This provides care for patients experiencing an acute episode of mental illness and requiring an emergency admission.

Maple Court and Mulberry Court – two 18-bed wards providing inpatient rehabilition services for patients requiring recovery-orientated care.

Elm Court – a four-bed ward providing a step-down service for patients who are approaching discharge. This ward seeks to provide a transitional service between the ward and community environments.

The hospital had one registered manager, with sub-team managers for each ward. The service was registered to provide the following regulated activities:

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

Patients using Cygnet Churchill Hospital have a primary diagnosis of mental health issues such as schizophrenia, schizoaffective disorder, bipolar affective disorder or depression and may have additional complex needs. These additional needs may include issues related to substance misuse, resistence to treatment and behaviour which challenges services. The service aims to provide recovery and rehabilitation to patients through programmes led by occupational therapists and psychologists.

NHS commissioners from across the country refer patients to the service and the average length of stay is around 18 months. Most patients are admitted to the hospital from an NHS mental health inpatient ward. It classifies as a longer term high dependendy rehabilitation unit and all patients are subject to detention under the provisions of the Mental health Act at the point of admission. Patients are discharged from the service to a variety of settings. The majority of patients move to a community setting such as supported living.

We previously inspected Cygnet Churchill when it was Cambian Churchill Hospital in May 2017. We rated the service as 'good' overall and in all the five domains.

At this inspection, the hospital comprised of two core services. We report both core services under the long stay / rehabilitation core service as the acute core service was significantly smaller than the long stay / rehabilition core service.

Our inspection team

The team that inspected the service comprised two inspectors and three specialist advisors. One specialist advisor was an acute nurse, and the other two were nurses working in mental health rehabilitation services.

Why we carried out this inspection

We undertook this inspection as part of our ongoing comprehensive mental health inspection programme following it moving to new ownership.

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?

The inspection was completed on 29, 30 and 31 October 2019. It was an unannounced inspection and we inspected all key lines of enquiry in the five domains (safe, effective, caring, responsive and well-led).

Before the inspection visit, we reviewed information hat we held about this location and requested information from the provider.

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients
- spoke with the hospital manager
- spoke with two ward managers
- spoke with eight other staff members including doctors, nurses, an assistant psychologist and administrative staff
- reviewed three staff recruitment files
- attended and observed one multidisciplinary meeting
- looked at six care and treatment records of patients
- carried out a specific check of the medication management on the unit and reviewed nine prescription cards and associated paperwork
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients across all the wards told us staff treated them with kindness and respect. Patients complimented staff for their work and support. They told us staff were good and they liked them and that saff encouraged them to speak up when things were wrong. Patients said they felt listened to and said staff made improvements to the service when concerns were raised.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **good** because:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and rapid tranquilisation minimally, and only after attempts at de-escalation had failed.
- 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 service used systems and processes to safely prescribe, administer, record and store medicines.
- The wards had a good track record on safety. 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.

However:

- The service stored information about patient care in more than once place and this meant that staff might not be able to find essential information in a timely manner.
- At the time of the inspection, the provider did not stock emergency Naloxone medicine despite admitting patients who presented with risks for illicit opiate and substance misuse. The provider had since sourced and stocked emergency Naloxone medicine.
- Although staff used rapid tranquilisation rarely, we saw one example where staff had not followed the provider's policy around follow up physical health checks in full.

Summary of this inspection

Are services effective?

Good

We rated effective as **good** because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected a patient's assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, to support for self-care and the development of everyday living skills, and to meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- 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 a 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.
- 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.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- On Maple Court, detention paperwork for patients detained under the Mental Health Act did not clearly show that all efforts had been made to inform the nearest relative of the patient's detention. There were also examples where patients had not been offered the chance to have a hospital manager's hearing before the end of their detention, which they should have had.

Are services caring?

Good

We rated caring as good because:

- 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.

Summary of this inspection

- Patients told us staff treated them well. Patients complimented staff for their work and support. They told us staff were good and they liked them and that saff encouraged them to speak up when things were wrong. Patients said they felt listened to and said staff made improvements to the service when concerns were raised.
- 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.
- Staff informed and involved families and carers in a patient's care appropriately.

Are services responsive?

Good

We rated responsive as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The design, layout, and furnishings of the ward/service 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 a good quality and patients could make hot drinks and snacks at any time.
- The wards met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff did not make notifications to external bodies as needed. We found a number of notifiable incidents, such as allegations of abuse in relation to service users, that had not been reported to the Care Quality Commission.
- The service had not implemented the recommendation from a previous inspection of stocking Naloxone.

However:

Summary of this inspection

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff said they felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

Detailed findings from this inspection

Mental Health Act responsibilities

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

All staff were trained in the Mental Health Act and its Code of Practice. The provider had a Mental Health Act lead to provide staff with support and guidance. We found most staff understood and adhered to their responsibilities under the Mental Health Act and its Code of Practice, but there were examples of staff not following all Code of Practice recommendations on Maple Court. This was around informing the nearest relative of a patient's detention and ensuring a hospital manager's hearing took place before the end of a patient's detention.

Staff completed six monthly audits to ensure that the Mental Health Act was being applied correctly. We found that while the issues in relation to Maple Court had been picked up in the audits, action had not been taken to make improvements.

Staff explained patients' rights to them on admission and regularly thereafter and ensured patients could access an Independent Mental health Advocate.

We reviewed consent to treatment documentation and all patients were prescribed medicines in acccordance with the Mental Health Act. Medicines were reviewed regularly and second opinion approved doctors sought when required.

The CQC completed a Mental Health Act monitoring visit to the hospital on 30 October 2018. Issues identified included records relating to provision of Section 17 leave forms to patients, patient access in certain areas of the wards and patient involvement in the care planning. At this inspection, we found that some patients were still not given their Section 17 leave forms.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff were trained in the Mental Capacity Act and staff had a good understanding of its application and principles. Care records included capacity assessments in relation to specific decisions, such as care plans and finances.

Mental capacity assessments were reviewed regularly and monitored through six monthly Mental Capacity Act audits.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Requires improvement	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Notes

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

Safety of the ward layout

Staff did regular risk assessments of the care environment. Staff we spoke with were aware of the potential ligature points on the wards and how these risks were managed. The provider had completed a ligature risk assessment for all the wards in June 2019.

Juniper Ward, the male acute ward, was opened in summer 2019 to ensure that it provided a safer, more low ligature risk environment for patients. The ward had soft furnishings and some anti-ligature fittings. Staff were aware of how to manage those that were present.

The longer stay high dependency rehabilitation wards, Maple, Mulberry and Elm court, were well-furnished and suitable for the purpose they provided. The wards were locked but staff allowed patients to leave the wards based on individual risk assessments and granting of leave. The environment on the wards was recovery-focused.

Staff were able to observe all parts of the wards from the nurses' station through the use of windows, convex mirrors and closed circuit television.

Patients had access to their own bedrooms with en suite facilities. The wards complied with guidance on single-sex accommodation. All wards were single-sex only. The hospital had recently upgraded all the viewing panels on patients' bedroom doors, and these could now be operated from both sides of the door. This meant that staff could do routine observations safely while respecting patients' privacy and dignity.

Staff had access to an alarm system which could be used to alert other staff in the case of an emergency. Patients also had access to a nurse call system through alarm bells on the wall of each room.

Maintenance, cleanliness and infection control

All wards were clean and well-maintained. We saw that regular cleaning took place and the furnishings were appropriate for the wards. Patients had access to well-furnished and comfortable bedrooms and lounges.

Staff adhered to infection control principles, including handwashing. There was an infection control lead for the site who carried out regular checks of the clinic rooms. We observed staff washing their hands at appropriate time throughout the day.

Clinic room and equipment

The clinic room was equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. The clinic room was clean and well-maintained. Staff completed a cleaning checklist for the clinic room every weekend and this was checked by the infection control lead.

At the previous inspection in May 2017, we told the provider that they should ensure that the equipment in the emergency response bags includes a pulse oximeter. At this inspection, we found that this had been done.

At the previous inspection in May 2017, we told the provider that they should ensure that the contents of the first aid

kits are routinely checked to ensure that all of the appropriate items are in the kit. At this inspection, we found that the provider had engaged weekly checks to ensure that everything on the checklist was in the bags. The findings were corroborated by the pharmacist. The checklist was audited by the heads of care.

Safe staffing

Nursing staff

The ward managers had calculated the number and grades of nurses and healthcare support workers required to safely meet the needs of patients and this number was matched on most shifts. The hospital managers could adjust the staffing levels depending on patient need. Staffing was increased if more than one patient was put on enhanced observations and staff reported this was usually covered quickly.

The service had not used any agency staff since summer 2016 and all shifts were covered by their substantive or bank staff. Bank staff are permanent staff members who take on extra shifts if they wish to and a shift needs filling.

There was always a qualified nurse available on all the wards. At the time of the inspection, Maple Court had one nurse vacancy and one support worker vacancy. The hospital operated within a structure of core staffing numbers which were established using a staffing matrix and, within this, allowances were made to ensure patients had 1:1 time with their key workers.

Patient leave was rarely cancelled because of not enough staff. Most patients had unescorted leave and did not need a staff member with them. However, where escorted leave was cancelled, it was usually due to ward acuity levels and rescheduled for another time.

There were enough staff around to carry out physical interventions. However, this was rarely used on the wards. Staff used their de-escalations skills to manage patients who showed signs of stress or agitation.

Ward managers monitored staff sickness and absence levels on each ward. The sickness levels had been high in the past but at the time of this inspection sickness and absence levels were very low.

In the twelve months leading up to June 2019, the hospital had had 17 out of 115 staff leave. This was primarily due to personal or career progression opportunities.

Medical staff

The service had a full time consultant psychiatrist and a specialist doctor in place. Nursing staff spoke positively about the medical staff and said they were very involved and responsive to any patient concerns.

There was adequate medical cover day and night and a doctor was able to attend the wards quickly in an emergency. The service had an on-call doctor and consultant for out-of-hours concerns.

A GP visited the hospital on a weekly basis to see those patients who were unable to attend appointments at the surgery.

Mandatory training

Staff had received and were up-to-date with appropriate mandatory training. Staff submitted all their mandatory training completion forms to the administrative staff, and a summary was sent to the respective ward managers. Staff had achieved an 84% compliance in competing the training that the provider had set as mandatory. Some staff were booked onto training courses within the three months following the inspection to ensure that everyone had the necessary skills to complete their roles.

Staff were trained in Basic Life Support (BLS) and Immediate Life Support training (ILS). The management team carried out simulation training twice a month. The Immediate Life Support training was at 72% at the time of the inspection. However, the remaining staff were all booked onto training sessions for November 2019. The Safeguarding Level 3 training was at a lower percentage as the provider was awaiting further training dates from the local authority provider. The manager informed us that training was set for the month after the inspection.

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed six patient records. Records showed that staff carried out a risk assessment of patients upon admission and updated it regularly, including after any incident.

Staff used a recognised risk assessment tool which was provided to them in the electronic recording system.

Management of patient risk

Staff were aware of and dealt with any specific risk issues that were individual to patients. For example, a patient

posed risk by smoking in their bedroom. For this patient, staff developed a risk management plan that including body searches upon return from leave, offering smoking cessation sessions and psychotherapy sessions to cope with their smoking habits. Staff had developed a motivational plan with the patient to discourage them from using cigarettes on the ward.

Staff followed good policies and procedures for the use of observation and searching patients or their bedrooms. We saw that searches were targeted and only carried out where there was risk. Patients were only placed on one-to-one observations where they were assessed as needing this to keep them safe. At the time of inspection, there were no patients on one-to-one observations.

Staff applied blanket restrictions on patients' freedom only when justified. At the time of inspection, we did not find any blanket restrictions applied on the wards.

Staff had identified a risk across the wards of patients using illicit drugs whilst on leave from the ward. In response, staff carried out targeted body and room searches, used sniffer dogs on occasions and offered education sessions to patients who were actively or historically using illicit substances. The consultant also said that they discussed harm minimisation methods with patients, to encourage them to reduce their use of illicit substances or the harmful effects of them.

Use of restrictive interventions

Staff only used restrictive interventions, such as restraint, as a last resort. All staff we spoke with told us that they used restraint very minimally and usually relied on verbal de-escalation to manage difficult situations. Staff only used restraint after de-escalation had failed and used the correct techniques. In the period 16 September 2019 to 16 October 2019, the service reported five restraints across all the wards. The provider had not reported any prone restraints for the twelve months leading up to the inspection.

Support workers in the teams led the implementation of the Management of Actual or Potential Aggression (MAPA) programme. The MAPA programme enables staff to manage disruptive, challenging and aggressive behaviours in a safe, non-harmful manner. Four staff members across the wards were trained in this intervention. Staff were highly positive about the impact of this programme and felt that it was used well by the different staff groups and teams. All staff were trained in de-escalation skills and used these appropriately. The service had plans to train more staff in the MAPA programme intervention.

Staff used rapid tranquilisation as a last resort only. Rapid tranquilisation is the use of medication for sedation. We found that instances of rapid tranquilisation use were minimally at this service. However, we identified one example from August 2019 where staff gave rapid tranquilisation to a patient on Juniper Ward. The provider's policy stated that a patient's vital signs had to be checked every five to ten minutes for the first hour, and then every half an hour until ambulatory (able to walk unnassisted). In this case, we noticed that the patient's physical health checks stopped after the first half an hour, and there were no further records of checks being carried out or the patient refusing the checks. While general observations took place, staff did not follow the provider's policy in adhering to the post-administration checks.

The provider did not use seclusion. Juniper ward, with some of the most unwell patients, had a de-escalation room which staff used as a calming space for patients. This was a low-stimulus area, and patients were free to come and go as they pleased.

Staff had also developed activity 'grab and go' boxes to reduce the use of restrictive interventions and to give patients a calmer outlet during stressful times.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate. We found that staff made alerts to the local authority regarding any safeguarding concerns and kept a detailed safeguarding 'tracker' which monitored the progress of these referrals. There was a dedicated safeguarding lead who staff could approach for support and guidance on safeguarding matters. However, the service did not always notify the Care Quality Commission of alerts made for allegations of abuse in relation to service users.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.

Staff followed safe procedures for children visiting the ward. Any children visiting the hospital were seen in a visiting room by reception.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff access to essential information

Staff used a number of systems for the recording of patient notes, both electronic and paper-based. Most of the notes were stored on the electronic systems and some were kept in paper files. For example, patient records were available on the online shared drive, an electronic software system and on paper. While most staff were able to find the required information with ease, some staff were not so confident with the multiple systems of recording. The progress notes, care plans and risk assessments were all stored on the internal electronic care record system. The detention paperwork, physical health monitoring forms and medication documentation were all stored in paper files.

Medicines management

Staff followed good practice in medicines management, including the transport, storage, dispensing, administration, medicines, reconciliation, recording and disposal. We found that staff worked in line with national guidance.

Staff were able to support patients who wanted to self-medicate and regularly reviewed their medicine intake in accordance with the prescription. There were no patients who were at the stage of self-medicating at the time of our inspection.

A pharmacist visited the wards twice a week and also audited the wards for medicines management, clinic room standards, prescribing standards, administration records, Mental Health Act documentation and medicine reconciliation.

The service had had four medicines errors in the six months to June 2019. These included two missed depot injections, one administration of drugs to the wrong patient, and one administration of expired drugs to a patient. We reviewed the records and the service had implemented clear learning from these incidents.

Staff regularly reviewed the effects of medication on patients' physical health and in line with guidance from the National Institute for Health and Care Excellence.

At the last inspection in May 2017, we told the provider that they should ensure there is an emergency supply of Naloxone available. Naloxone is a medicine that can temporarily reverse the effects of an opiate overdose, providing more time for an ambulance to arrive. Some patients, who may misuse substances during leave from the service, may be at risk of an opiate overdose. At this inspection, we found that Naloxone was still not available on-site despite the service looking after patients with a history of opiate misuse. During the inspection, we identified a number of patients who were at a risk of opiate overdose. We informed the manager of the risk, and they reported that they were ratifying the immediate life support policy with details on the equipment they needed to order, including Naloxone. The manager informed us that the Intermediate Life Support training included training on the use of Naloxone, and this was being rolled out to all nursing staff. Since the inspection, the provider had sourced Naloxone to store on site, and this was supported by an updated immediate life support policy.

Track record on safety

We were informed of three serious incidents that had occurred at the service in the twelve months leading up to the inspection. The first incident was about a patient death, and the coroner report concluded that staff responsed well to this incident. The second incident concerned a patient who went missing while on leave. The patient returned three weeks later with severe blisters on their feet. Staff were able to share learning from these incidents and had a robust mitigation plan in place to ensure they were not repeated. The third incident revolved around the fire alarm setting off, and a patient leaving the ward to go onto the restricted reception area. Since this incident managers had ensured that a staff member was posted by the ward exit doors in the event of a fire alarm.

Reporting incidents and learning from when things go wrong

All staff we spoke with knew what incidents to report and how to report them. Staff were clear on the duty of candour and applied this when needed. The duty of candour is a statutory (legal) duty for staff to be open and honest with patients, or their families, when something goes wrong in the patient's care.

Staff received feedback from investigations of incidents, both internal and external to the service. Staff were given opportunities to meet and discuss this feedback. Staff were able to give examples of learning from incidents. For example, staff had some issues with patients accessing drugs for legal highs while on leave, and two patients had

Long stay or rehabilitation mental health wards for working age adults

Good

ended up in the emergency department because of their substance misuse. Management have since discussed the issue with local shop keepers and provided a training session for staff on substance misuse and legal highs.

The service had had a number of patients not returning from their leave within the agreed time and going absent. Staff had issued patients with cards containing contact details of the hospital. Patients could use these cards when out on leave to inform the hospital of late return, or in emergency. The consultant reassessed leave at multidisciplinary and ward round meetings to evaluate if the risk of absconding had reduced or remained the same, and if leave granting should be changed.

Staff were debriefed and received support after a serious incident. Staff also had access to a monthly reflective practice session with the team psychologist in which they could discuss complex cases or recent incidents. Patients were supported and debriefed following incidents.

Are long stay or rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission. Staff assessed patients' physical health needs in a timely manner after admission. Staff developed care plans that met the needs of patients as identified during assessment.

We reviewed five care plans. We found that care plans were personalised, holistic and recovery-oriented. Staff updated care plans when necessary. Care records included current risk assessments and daily progress notes. Patients on the rehabilitation wards also had an account of their activities involvement and any recreational exercises they were engaged in. Patients on the rehabilitation wards had care plans in place relevant to their individual goals, treatment plans and self-management objectives. For example, patients had care plans around building self-esteem, losing weight and better health, relapse prevention and medicines management. One patient was supported to improve their understanding of the English language. Patients' records included sections on their communication and social needs, mental health needs, risk management, physical health, rehabilitation needs and a thorough nursing assessment. The care plans were reviewed on a monthly basis, and any personal needs of the patient and their views were clearly recorded.

The occupational therapist carried out an audit of the rehabilitation section of care plans across all four wards to improve triangulation between assessments, interventions and care plans. This helped to ensure that the care plans were personalised and written in collaboration with the patient.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and delivered in line with, guidance from the National Institute for Health and Care Excellence.

Staff supported patients with a range of their rehabilitation needs and worked with patients to reach their objectives. Staff offered a range of therapies to suit patients' individual needs, and these included cooking sessions with the occupational therapist, attendance at eat well groups, walking groups and exercise sessions. Patients also had access to college learning and work opportunities in and around the area.

The occupational therapist ran a vocational programme that offered paid work and pre-vocational training opportunities to patients. The service had good links with a vocational programme club that supported patients during their stay at the hospital and also offered work opportunities for when they got discharged to provide continuity. The service had engaged with various community input programmes to support patients' rehabilitation and recovery. In addition, they had leisure and social training in the community, adult learning at a local college, day trips to Madame Tussauds, London Zoo and Camden Market to facilitate independence. The occupational therapy team also offered a 'pre-engagement skills' pathway that used sensory strategies and evidence based 'remotivation process'. This supported patients to progress towards participation in more traditional forms of therapy.

The psychologist provided a range of group and individual sessions for patients. This included coping skills, anger management, solution focused therapy and cognitive behavioural therapy, dialectical behavioural therapy. The psychology team had implemented an updated rehabilitation programme, with focus on service users' strengths. The new approach integrated cognitive behavioural therapies into the Good Lives Model of rehabilitation and aimed to tackle limited engagement, to improve access to psychological therapies and encouraged a proactive attitude towards recovery.

Staff ensured that patients had good access to physical healthcare, including being able to see a specialist when needed. Records confirmed staff supported patients to a dental appointments. Similarly, the managers on Maple Court enabled a patient requiring an assessment for attention deficit hyperactivity disorder (ADHD) to be assessed through Cygnet Hospital clinicians. This meant that the patient would not have to wait long for an assessment on the statutory waiting list.

The staff team included a primary heathcare nurse who looked after patients' physical health needs across the four wards. We saw that staff regularly discussed patients' physical health and any possible side effects from their medicines. For patients with diabetes, staff monitored blood sugar levels on a daily basis, including before and after unescorted leave. They also had a diabetes care plan in place and we saw evidence to show that staff had arranged appointments for a patient at a diabetes clinic. The primary healthcare nurse ran the Clozapine clinic with the support of a senior support worker. Other support workers were enrolled in phlebotomy and electrocardiogram (ECG) training.

Staff made good use of the charts for modified early warning score (which is a tool to monitor whether a patient is becoming physically unwell) and these were consistently filled out.

Staff supported patients with their nutritional needs and ensured that any specialist requirements, such as sugar-free, were met. Staff supported patients to live healthier lives. For example, through participation in smoking cessation schemes, healthy eating advice and managing cardiovascular risks. The service had been smoke free for a year before the inspection. Patients were allowed to use electronic cigarettes in their bedrooms. Staff followed the provider policy regarding smoking paraphernalia and the storage thereof. The pharmacist and primary healthcare nurse were training in smoking cessation support. Staff adhered to best practice in implementing a smoke-free policy.

Skilled staff to deliver care

The team included and had access to a range of specialists to meet the needs of patients on the wards. This included nurses, a doctor, a psychiatrist, psychologists, occupational therapists and a physical health nurse. Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patients.

The managers provided new staff with induction and appropriate information to fulfil their roles. The induction for all staff included the ward environment, potential ligature risks, managing visitors, confidentiality, lone working, personal alarms, air lock and security systems. Management provided the clinical staff with additional induction which included clinical supervision expectations, the incident reporting system, multidisciplinary working and documenting, management of client risk and risk overview, patient and carer involvement and medication management.

The managers ensured that staff had access to regular supervision, appraisals and team meetings. At the time of our inspection, 90% of staff had received quarterly supervision sessions. Staff across the service said that they well supported by their managers and had access to formal and ad hoc supervision. We also saw evidence of some group supervision happening.

The ward managers supported the professional development of staff and provided them with opportunities to further their skills and knowledge. For example, the provider had a development programme in place to support specialist doctors to develop to be consultants. In addition, healthcare support workers were able to train in a nursing associate course.

Members of the psychology team also offered specialist training sessions, case consultations and reflective practice on a regular basis, alternating different types of staff support according to the wider team needs. Within these sessions, staff were able to update their knowledge and clinical skills, review complex cases in a multidisciplinary setting, as well as reflect on their own practice in a constructive environment.

The hospital manager had put additional training sessions in place to address training needs such as legal highs and attention deficit hyperactivity disorder (ADHD). All staff across the different wards had the opportunity to work on the acute ward for people with mental health problems to gain experience in acute mental health care. Similarly, all staff had access to monthly training and development sessions run by different multidisciplinary teams with a focus on improving quality of care and clinical knowledge. The topics for these sessions were usually decided by staff training needs.

Some staff had received substance misuse training to help them provide efficient care for patients with a history or ongoing risks of substance misuse.

Juniper ward, the male acute ward, was opened in summer 2019, and management provided a series of training sessions for staff to ensure that everyone was skilled to provide acute mental health care. Staff were given the opportunity of visiting other Cygnet acute services to gain experience. Management recruited someone with existing acute mental health care experience to provide consistency and direction for the ward.

At the time of the inspection, the service was in the process of recruiting a medical secretary for the Juniper ward consultant. This was to support the consultant with their medical documentation and letters, so they gained more time for direct patient care.

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings which took place on a weekly basis. The meetings were attended by a range of staff professionals, including nurses, doctors, pharmacists, occupational therapists and support workers. We saw that staff discussed essential details of the patients' care at this meeting, including a daily risk assessment, rehabilitation progress and discharge planning. The discussions were innovative and proactive and staff were encouraged to find solutions for issues before they escalated into risks. At the time of our inspection, the teams were using a whiteboard for patient details. However, the consultant had ordered new electronic screens for future use.

Nursing staff shared information about patients at handover meetings within the team. The handover took place twice a day, one for the morning and one for the evening shift. The ward managers worked one long shift per month to observe the team working and handover process. We observed a morning handover, and found staff effectively captured any risk issues from the previous day and planned proactively for the coming day. Management discussed any staffing issues and whether bank staff were required to fill any shifts for the day.

The teams had effective working relationships with other teams within and external to the organisation. This included the GP, housing associations and voluntary organisations. Staff tried to facilitate the attendance of care coordinators at multidisciplinary meetings, whether in person or by teleconference. Staff also built good relations with local community programme organisations that could continue to support patients following discharge. As some patients were from out-of-area placements, this could not always be facilitated.

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

Staff had training in the Mental Health Act, the Code of Practice and the guiding principles. At the time of our inspection, 93% of staff had completed the training on the Mental Health Act.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. The provider had relevant policies and procedures that reflected the most recent guidance, and staff could access this.

The teams had a Mental Health Act lead who supported staff with any questions regarding the Act and carried out audits to ensure all documents were in order and filled out appropriately. On Maple Court we found some examples where documentation did not clearly show that the staff had attempted to inform the nearest relative of the patients' detention. Also, we found that four out of fourteen patients had not had a hospital manager's hearing before the expiry of their section. It was not clear from the records why these had not taken place.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand and this was repeated and recorded as needed. Informal patients were informed of their rights and leave notices were displayed on the ward doors. There were no informal patients at the time of our inspection.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff ensured that patients were able to take their Section 17 leave once this had been granted. However, in some cases we found no evidence to suggest that patients' section 17 forms had been shared with them.

Staff completed six monthly audits to ensure that the Mental Health Act was being applied correctly. We found that while the issues in relation to Maple Court had been picked up in the audits, action had not been taken to make improvements. The last audit was completed in May 2019 and was carried out every six months.

The mental health advocacy service visited patients twice per week. Patients felt able to raise concerns with the advocate freely.

The service had arrangements in place to monitor their adherence to the Mental Capacity Act. However, we found one example in Maple Court where the capacity to consent was not completed in relation to a form authorising treatment for a patient.

Good practice in applying the Mental Capacity Act

Staff had a good understanding of the Mental Capacity Act and knew how to carry out capacity assessments. At the time of our inspection, 89% of staff had completed the training on the Mental Capacity Act.

The service had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and how to access it.

Staff were able to gain advice about the Mental Capacity Act from their consultant psychiatrists and Mental Health Act administration team.

Staff took all practical steps to enable patients to make their own decisions. This included enabling patients to have access to an interpreter or signer where needed to express their wishes and concerns.

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

Good

Kindness, privacy, dignity, respect, compassion and support

We spoke with five patients. They told us that staff treated them with kindness and respect, and that they were responsive to their needs. Staff interactions with patients showed that they were discreet and supportive of patients where needed.

Staff supported patients to understand and manage their care and treatment. We saw that staff directed patients to other services when appropriate and supported them to access those services. This included supporting patients with their housing applications and welfare maintenance.

Patients told us that staff treated them well and behaved appropriately towards them. The hospital had a partnership with a local charity to ensure that patients had an assortment of goods to leave with upon discharge. This meant that patients could make a new beginning for themselves upon discharge. The hospital also worked to provide 'soothing' boxes for patients which could be used when patients felt sad or distressed and to help them manage their emotions.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the ward and to the service. Staff provided patients with leaflets on the various rehabilitation services available and how they could include them in their treatment plan.

Staff involved patients in their care and treatment planning. Patients were invited to their clinical review meetings and we saw their views were recorded in care notes.

The wards held daily planning meetings to help patients plan their day and what activities and therapies they would like to take part in. Patients were also supported to create personalised timetables based on their identified interests and needs to balance their time use.

Staff enabled patients to give feedback on the service they received. Patients were involved in the weekly community meetings on the wards, and took turns chairing the meeting. The patients we spoke with said any issues that were raised in the meeting were usually taken on board by staff and improvements to the service were made.

Long stay or rehabilitation mental health wards for working age adults

Good

Patients were also given regular opportunities to feedback on the therapy timetable, with suggestions on what they found helpful and enjoyable and what they would like to see added or improved.

The service had carried out a patient-wide garden project survey in summer 2019 to gain feedback on how patients wanted to see the garden renovated. As a result of patient feedback, turf grass had been laid out and additional sports equipment had been purchased. Patients also had access to a garden group and some barbeque sessions took place at varying times of the year.

The service had also engaged patients in a survey to reduce the number of patient absences without leave. Patients were asked for the reasons they were likely to go absent without leave, and how they would like to be supported reduce the likelihood of this happening. As a result of patient feedback, the service had introduced hospital contact cards and was piloting the use of location connective (GPS) smart watches with some patients.

Patients also had the opportunity to be involved in interviewing new staff and to attend governance meetings.

The service had engaged in various events and celebrations to encourage patient involvement. For example, summer barbeques, religious celebrations, hospital wide film nights and competitions. On some occasions, these events had also been open to families and friends.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. Staff tried to set up a carers' forum but had a poor uptake and attendance. Instead, they ensure that carers are involved in ward rounds, care planning meetings and were provided with informal support. This included staff making themselves available for carers that wanted to express any concerns or had questions and signposting them to carers' opportunities in the community.

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

Good

Access and discharge

Bed management

The service had four wards, of which three were longer stay high dependency rehabilitation wards and one was an acute ward for people with mental health problems.

Elm Court, a four bedded step down unit for patients undergoing rehabilitation, was also available as an alternative admission area for patients with autism-spectrum disorder (ASD) who required quiet space. At the time of the inspection, there were two patients on this ward. Elm Court had free patient access without an airlock and provided a more community orientated environment for patients.

The average length of stay for patients requiring rehabilitative care at the hospital was 18 months. This is within the expected national average length of stay of 18-20 months for a ward of this type. The turnover at the acute ward, Juniper ward, was quick and usually patients were discharged or transferred within a few weeks. Patients on all wards came from a diverse set of locations, and admission was not limited to a certain catchment area. For patients who were from out of area regions, staff organised teleconferences and coordinated visiting invites to the family and care coordinators to ensure that everyone was involved in the provision of care.

There was always a bed available when patients returned from overnight leave. The ward managers and lead nurses ensured that patients were not moved between wards during an admission episode unless it was in the patient's interest and justified on clinical grounds. Patients were discharged and transferred between wards and services at an appropriate time of day.

Discharge and transfers of care

Staff planned for patients' discharge, including good liaison with care managers and coordinators. Patients could be discharged from any ward. Staff usually included discharge planning within three to six months of a patients' arrival

and we saw this was discussed at multidisciplinary and care review meetings. Patients well enough to move on but needing some support with transition were transferred to Elm Court to aid discharge preparation.

On Mulberry Court, there were three delayed discharged at the time of the inspection. The patients were preparing to discharge and organising their self-medication management or awaiting ongoing accommodation. On Juniper, there were three delayed discharges due to lack on onward placement for the patients. Staff were working to find accommodation or alternative care placement for these patients and exploring avenues within the patients' own regions.

Patients were usually discharged into the care of their local community mental health team. Staff supported patients during referrals and transfers between services. Staff also ensured that patients had support in place for any additional needs they may have, including substance misuse or benefits support. This was discussed during care planning with the patients and staff signposted them to any resources within the community they could approach.

Facilities that promote comfort, dignity and privacy

Patients had their own bedrooms, with en suite facilities, which could be personalised to suit their personal preferences. Patients had somewhere safe to store their possessions.

Staff and patients had access to a full range of rooms and equipment to support treatment and care. This included a communal dining area for patients and staff to eat together, a gym, three therapy kitchens, a library, a multi-faith room, a barber shop, therapy rooms, an art studio, music studio, internet café and games room. Staff also had access to a clinic room where they could examine patients' physical healthcare. Patients we spoke with said that they were able to make phone calls in private.

Patients had access to a variety of communal facilities to aid with their rehabilitation. This included a communal eating area for patients and staff together, gym, recreational spaces such as an occupational therapy kitchen, activity room and garden. The activity room, garden and kitchen were used under staff supervision. The service had plans to introduce more sports equipment in the outdoors space for patient use.

Patients had access to quiet areas on the wards where they could sit for reflection and to meet visitors. Patients also had access to a garden space with recreational grounds and seating areas. The hospital had an ongoing garden project in which they sought to make improvements outdoors in partnership with patients and relatives.

Patients said that the food was of good quality and we observed that most patients seemed to enjoy their meals and had access to a variety of choices. Patients could make and had access to hot drinks and snacks at any time of day or night. The wards operated a protected lunch time between 12.30 and 2pm, during which time no visitors or leave could be facilitated, unless it was for exceptional circumstances.

Patients' engagement with the wider community

Staff supported patients to access education and work opportunities. For example, patients were supported to find paid work opportunities where possible. Previous opportunities include working in a Chat Café and as a council representative. The Chat Café was a café patients could use to socialise with other patients, but also as a hub for psychology interventions. The intervention was to create a livelier and more engaging environment for patients who may otherwise be reluctant to engage in psychological interventions. The hospital had links with vocational projects in the local area and some patients had accessed opportunities in mechanics and literary courses.

Staff supported patients to maintain contact with their families, friends and carers. This included encouraging patients to develop and maintain relationships with people that mattered to them, both within the services and in the wider community.

The occupational therapy team had developed a 'community skills' programme to develop patients' confidence and skills when accessing local facilities and using public transport.

Patients had access to wide range of therapies and activities, including shopping and cooking, crafts, swimming and days trips to London museums and areas of interest. Patients on Maple Court and Mulberry Ward also had access to a pool table in the lounge. Patients were also able to engage in weekly therapy sessions at the local sports and leisure centres, parks and swimming pools.

Meeting the needs of all people who use the service

Long stay or rehabilitation mental health wards for working age adults

Good

The service made adjustments for disabled patients. There were rooms available for patients requiring wheelchair access with a step-free bathroom. The occupational therapy team also completed mobility and function assessments for all patients to support them accessing the service. They prescribed aids and adaptations where needed to enable patients to function with maximum independence. This included mobility aids, bathing equipment and adapted cutlery and crockery.

Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain. These could be viewed on posters and leaflets throughout the service.

Staff made information leaflets available in languages spoken by patients. They could get these from the internal staff intranet. The hospital manager ensured that staff and patients had easy access to interpreters and signers where needed.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. Staff ensured that patients had access to appropriate spiritual support as required. Patients informed us that when any concerns came up regarding the hospital food, they were usually able to meet with the kitchen staff, and provisions were made to change the menu or support individual needs.

The hospital manager was in the process of providing patient access to ministers of religion for their spiritual well-being. The service supported patients' spiritual needs and enabled them to access services in the community where needed.

Staff enabled patients to express their individual interests and personal choices. This included supporting patients' sexuality and creating an environment in which patients felt free to express themselves. Staff could give examples of how they protected patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, one patient was supported in expressing their personal choice clothing and staff ensured they felt able and confident in doing so.

Listening to and learning from concerns and complaints

Patients we spoke with knew how to complain or raise concerns. They told us they usually received feedback on any concerns they had raised, and that most concerns were dealt with immediately without requiring a formal complaint.

Staff knew how to handle complaints appropriately. Staff received feedback on the outcome of investigation of complaints and acted on the findings.

In the twelve months leading up the inspection, the service received 20 complaints. Two of these complaints were withdrawn, and one of the complaints was upheld. We saw evidence of action being taken to make improvements to the service. All complaints were responded to within the provider's agreed timescale and in accordance with the provider's policy.

The service had introduced a quality improvement project on Juniper Ward which included a staff and patients group reflection on the service performance. Staff and patients found this a highly positive addition, and staff told us it helped them to make improvements to the service.

In the twelve months leading up to the inspection, staff members had received 58 compliments from patients and family members, including positive notes on patients' presentation following their stay in the hospital. Some patients had complimented staff about the care they provided and said they felt better after their stay.

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

Requires improvement

Leadership

Leaders had the skills, knowledge and experience to perform their roles. Leaders had a good understanding of the services they managed.

The hospital manager had general oversight and responsibility for the hospital and care provided, and ward managers took responsibility to oversee the ward staffing, supervision and appraisals.

The hospital manager and ward managers had a good understanding of the services they managed and could

explain clearly how they worked to provide good care to patients. Elm Court, the four-bedded step down ward, had no permanent ward manager. However, the other three ward managers took turns to manage the ward and were familiar with the patients' needs and staffing requirements.

Staff informed us that the lead nurses, ward managers and hospital manager were highly visible in the service and approachable for patients and staff.

Leadership development opportunities were available for staff. Three staff were undertaking management apprenticeships at the time of the inspection.

Vision and strategy

Staff knew the provider's vision and values and how these were applied in the work of their team. The Cygnet values, 'integrity, trust, empower, respect and care' were discussed in staff meetings and during appraisals.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. For example, prior to the re-opening of Juniper Ward, management engaged staff in conversations about what service to provide and how to meet staff and patient needs. Staff and management decided on an acute service, and training was provided to ensure staff compatibility with the new service provision. The re-opening of Juniper Ward was phased to manage the process and patient care safely.

Culture

Staff said they felt respected, supported and valued. All staff we spoke with said they felt positive about the service they provided. The psychologist, who had started in post recently, had introduced informal coffee mornings for staff to engage them and break down any barriers between nursing and clinical teams.

The most recent staff survey from 2019 showed that 85% of staff enjoyed working at the hospital; 95% felt confident in reporting concerns; seven out of ten people would feel confident for a relative to be supported by Cygnet healthcare and 90% of staff understood the Cygnet values.

Staff had access to NHS employee discounts, free meals on site and an annual pay rise.

Staff said they felt able to raise concerns without fear of retribution and were aware of the provider's whistle-blowing process.

Staff appraisals included conversations about career development and how this could be supported.

The service monitored its absence and sickness rates and had worked successfully to reduce the overall hospital staff sickness levels.

Governance

There was a clear agenda for what must be discussed at a ward, team and hospital level meetings. Staff had access to monthly governance meetings in which they discussed essential information such as risk governance, learning from incidents and complaints. The minutes from this meeting were available for staff who were unable to attend. We found that staff discussed and implemented learning from incidents and had records to prove this.

The hospital manager also attended the regional South East corporate governance meeting, along with hospital managers from other sites in the area. This meeting was used to share learning and development between the different Cygnet sites. For example, learning was shared from another Cygnet hospital regarding the case of a patient death by ligature and all hospitals in the region had implemented some learning from the incident.

Staff understood the arrangements for working with teams both internal and external to the hospital to meet the needs of patients. For example, staff worked well with the local GP surgeries, housing associations, college and social services.

We reviewed three staff recruitment files and found that all the necessary documents including disclosure and disbarring service (DBS) certificates, right to work, references and medical competencies were all completed and stored appropriately.

Management of risk, issues and performance

Staff could view the hospital risk register and could escalate concerns to the hospital manager. Staff concerns matched those on the risk register. This included trends identified from incidents (for example patients absent without leave).

The service had plans for emergencies, including adverse weather or a flu outbreak.

Information management

Long stay or rehabilitation mental health wards for working age adults

Good

Staff had access to the equipment and information technology needed to do their work. Information governance systems included confidentiality of patient records. However, the care records system was not always easy to navigate and resulted in staff keeping information about care in several different places. For example, some patient care information was kept electronically, and some information was stored on paper. Most staff were confident in the use of this system. However, we found that some staff were not able to find information in a timely manner.

Ward managers and the hospital director had access to a performance dashboard. The dashboard provided information on the performance of the service, staffing and patient care. Managers used the dashboard to give them an overview of overall hospital performance, and used ward specific audits to pick up on ward-based issues. We found that the hospital and ward managers had a good oversight of the services they provided.

Staff did not make notifications to external bodies as needed. For example, between 01 January 2019 and 29 October 2019 we found 17 incidents of allegations of abuse in relation to service users that were not reported to the Care Quality Commission. As part of the registration conditions, the service was required to notify the commission of any incidents relevant to allegations to abuse or abuse in relation to a service user. However, we found that staff had reported all incidents to the local authority, and were supporting patients appropriately throughout the investigation of the allegations. The service manager kept a 'safeguarding tracker' to monitor the progress of all safeguarding referrals made to the local authority. Since the inspection, the service retrospectively notified the CQC of all notifications due and put more robust procedures in place to ensure these continued to be notified at the time of any future notifiable instances.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services it provided, for example, through the intranet, community and staff meetings and newsletters.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients had access to a weekly community meeting, which was chaired by a patient, in which they could give feedback or raise any concerns. Staff tried to set up a carers' forum, but due to lack of interest and attendance this was reviewed, with alternative measures to engage carers explored. For example, carers also had the opportunity to raise concerns or give feedback on care informally, through multidisciplinary meetings and at social events within the hospital. The hospital manager had an open door policy and patients, carers and staff could provide feedback directly. Patients were also able to attend the People's Council Meeting, after which they could arrange to meet with their Independent Mental Health Advocate on a 1:1 basis. The service carried out an annual patient survey in which patients to comment on staff attitudes, their involvement in care, information received about the care and treatment provided, decision making in care, nutrition and activities.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Learning, continuous improvement and innovation

The provider had engaged in a number of quality improvement initiatives to make improvements to the care and services delivered. For example, on Mulberry Ward and Maple Court, staff had completed a review of physical healthcare of patients to make improvements to the way physical healthcare was monitored and delivered for patients with mental health issues.

Staff also had opportunities to take part in monthly training and development sessions based at the hospital. These addressed various training topics based on staff developmental needs and had previously included discussions around: trauma-informed care, restrictive practice, vital signs monitoring and analysis and care plan writing.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the service send all required statutory notifications in relation to allegations of abuse to the Care Quality Commission without delay. Regulation 18(2)(e) (Registration) Regulations.

Action the provider SHOULD take to improve

- The provider should ensure they review the overall risks relating to their patient group, such as risk of overdose from illicit substances, and take appropriate action to acknowledge and mitigate these risks.
- The provider should ensure staff follow the provider policy when carrying out and recording physical health checks following the administration of rapid tranquilisation.
- The provider should ensure that all staff were confident in finding information relevant to patients' care in a timely manner.
- The provider should ensure that staff understand and carry out their responsibilities under the Mental Health Act 1983 and its Code of Practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The service did not submit all the required statutory notifications in relation to allegation of abuse to the Care Quality Commission.** **This was a breach of regulation 18 (2)(e).**