Cygnet Health Care Limited

Cygnet Hospital Blackheath

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 Blackheath provides psychiatric intensive care and low secure care to men over the age of 18 years.

Our rating of this service improved. We rated it as good because:

The service provided safe care. All patients and staff told us they felt safe. The ward environments were safe and clean. During this inspection, we found the provider had made improvements since our inspections in April 2018 and June 2020.

Medicines were prescribed in accordance with law relating to consent to treatment under the Mental Health Act 1983. Staff managed medicines safely.

The service had improved reflective practice and processes to ensure that learning from incidents, took place.

Managers also ensured that staff received regular clinical and managerial supervision which supported them in their role. Staff told us they were able to speak up and raise any concerns they had.

The wards had enough nurses and doctors to deliver safe and care to patients.

Staff minimised the use of restrictive practices and used restraint as a last resort.

Staff followed good practice with respect to safeguarding and had improved processes to ensure learning from safeguarding took place.

Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided, action plans were developed to make improvements.

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 service who would have a role in providing aftercare.

Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Since the last inspection there were improvements to the culture of the hospital. Staff felt respected, supported and valued. They could raise any concerns without fear and reported that their concerns were taken seriously.

Staff were provided with opportunities for development and career progression. Staff reported they were positive and proud to work for the provider.

Summary of findings

Governance processes operated effectively and performance and risk were managed well.

However:

Not all patients on Tyler ward had a copy of their care plan.

Planned activities for evenings and weekends did not always take place on Tyler ward.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Good 	Our rating of this service stayed the same. We rated it as good because: • Please see overall summary.
Acute wards for adults of working age and psychiatric intensive care units	Good 	Our rating of this service improved. We rated it as good because: • Please see overall summary.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Hospital Blackheath

Cygnet Hospital Blackheath has two wards. Tyler Ward is a 14-bed psychiatric intensive care unit and Meridian Ward is a 16-bed low secure ward. Both wards provide care and treatment to men over the age of 18 years.

Cygnet Hospital Blackheath is registered to provide: Assessment or medical treatment for persons detained under the Mental Health Act 1983; Treatment of disease, disorder or injury There was a registered manager in post at the time of the inspection.

We have inspected Cygnet Hospital Blackheath three times since 2015. At our last focused inspection in June 2020 we found no regulatory breaches.

At the comprehensive inspection in April 2018, we found the following breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 11 (need for consent) – medicines were not prescribed in accordance with law relating to consent to treatment under the Mental Health Act 1983.

Regulation 12 (safe care and treatment) – the staff team did not reflect on their work together to ensure learning from frequent incidents.

Regulation 18 (staffing) – staff did not receive appropriate supervision to enable them to carry out the role they were employed to perform.

At the April 2018 inspection we rated the hospital as requires improvement overall. We rated the psychiatric intensive care unit as requires improvement overall, along with requires improvement for being safe and effective. We rated caring, responsive and well-led as good. The low secure ward was rated good overall, and for all key questions except effective, which was rated requires improvement.

What people who use the service say

Patients said staff treated them well and behaved kindly. All patients told us they felt safe on the wards.

All patients commented that they were respected, treated well and listened to. They reported that staff were friendly, approachable, professional and could have regular one to one sessions.

Some patients on Tyler ward commented that planned activities in the evenings and at weekends did not take place.

We received feedback from three carers we spoke with. All carers told us that they were involved in their family members care and that overall staff were kind and caring.

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:

Summary of this inspection

- 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 both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with seven patients who were using the service and three carers or family members of patients who were using the service. Interviews with carers were completed by telephone. Our final carer interview was on 14 October 2021.
- spoke with the clinical nurse manager, regional operations director, hospital manager and medical director
- spoke with 16 other staff members: including consultant psychiatrist, doctors, nurses, occupational therapists, healthcare assistants, clinical psychologist, assistant psychologist, administrator, security manager and social worker
- spoke with an independent advocate
- attended and observed two situation report meetings and one multidisciplinary team meeting
- looked at four care and treatment records of patients
- carried out a specific check of the medicine management on both wards
- looked at three staff human resource files
- looked at a range of policies, procedures and other documents relating to the running of the service

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

Areas for improvement

- The service should ensure that activities scheduled for the evenings and weekend take place
- The service should ensure that each patient has a copy of their care plan

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Good

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

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 risk assessments of all wards areas and removed or reduced any risks they identified. Staff carried out a health and safety check of the ward environment on each shift.

The ward layout allowed staff to observe all parts of the ward. Closed circuit television (CCTV) was in place in the corridors and communal areas and recorded any activity taking place. Staff carried out regular observations to manage patient risk. The ward was a T shape and convex mirrors were in place to improve visibility at potential blind spots.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe, for example, by using observation, engagement and individual risk management plans for each patient. A ligature audit had been carried out in March 2021 which included photographs of ligature points. A ligature heat map was on display in the nurse's office. However, we found six ligature anchor points that had not been identified on the ligature audit. These were in an area of the ward that was not easily visible. The service took immediate action to remove the ligature points and antiligature door handles were fitted within the inspection period. The ligature risk audit was updated to reflect this.

Staff had easy access to alarms. Patients did not have access to the nurse call system. This system had been disabled. There had been a corporate review of nurse call systems across all Cygnet Hospital sites and we saw that works were due to take place to install a new patient call system throughout the hospital by the end of 2021. The registered manager reported that there had been delays in contractors visiting the hospital to carry out a full review. Where patients, were assessed as requiring the use of a nurse call bell, management plans were put in place such as enhanced observations.

Good

Forensic inpatient or secure wards

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. An environmental action plan was in place and this detailed the works planned for the ward which included redecoration, new flooring, new furniture and new bedroom doors. The estates team met monthly where any maintenance and estates issues were discussed, actions agreed and any issues escalated to senior management.

Staff made sure cleaning records were up-to-date and the premises were clean. Housekeeping staff were seen cleaning high touch areas throughout the day.

Staff followed infection control principles including appropriate handwashing techniques, use of personal protective equipment (PPE) including aprons, masks, gloves, and hand sanitiser was readily available. Staff accessed infection control training. Training was compliant at 100%. The clinical nurse manager was also the infection prevention control lead for the hospital.

Regular infection control and handwashing audits took place. The ward scored 98% at the August 2021 audit. Where any improvements were required these were shared at the team and clinical governance meetings.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet, shower and a clock. The seclusion room had not been used in the 12 months prior to our inspection.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked daily. The clinic room was well ordered, clean and tidy. Staff checked, maintained, and cleaned equipment. Staff ensured that equipment was correctly calibrated. Checks were being carried out regularly and where there were any gaps these were addressed by the clinical nurse manager.

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 staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Staffing was reviewed daily with the senior management team and for the following 24hrs within the daily situation report meeting.

The ward had vacancies for one ward manager, and two registered nurses. The service was actively recruiting into vacant posts, this included undertaking recruitment overseas. The service had reduced its use of agency staff. Staffing levels were maintained by the deployment of bank staff mainly and where required agency staff.

Where bank and agency staff were used these staff received an induction and were familiar with the ward.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The service used a staffing matrix which determined the numbers of staff required dependent on the number of patients and their acuity.

The clinical nurse manager could adjust staffing levels according to the needs and risk level of the patients.

Patients had regular one to one sessions with their named nurse. Patients we spoke with confirmed they knew who their named nurse was and that they spent regular time with them.

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.

Staff shared key information to keep patients safe when handing over their care to others, for example, situation report meetings were held daily as well as handover meetings between shifts. Staff told us they used these meetings to discuss any incidents that had occurred and update patient risk information.

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. Patients were seen and monitored in a timely way. The service operated an on-call system for out of hours.

Managers could call locums when they needed additional medical cover.

Mandatory training

Staff had completed and mostly kept up to date with their mandatory training to ensure they had the appropriate knowledge and skills to carry out their roles safely. Overall compliance for Meridian ward was at 94%.

The mandatory training was comprehensive and met the needs of patients and staff. Staff we spoke with said they felt confident carrying out their role and applied training to their practice. They were fully supported to carry out any additional required training. 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. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they 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

Good

Forensic inpatient or secure wards

Staff completed risk assessments for each patient on admission using a recognised tool. Risk assessments were reviewed regularly, including after any incident. The psychology department took a lead in patient risk assessments and used a range of evidence-based tools such as Structured Assessment of Protective Factors (SAPROF), short term assessment of risk and treatability (START) and Historical Clinical Risk Management-20 (HCR-20).

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. All staff we spoke with had a good understanding of each patient and the risks they posed. Patient risk assessment and management was discussed in the daily situation report meetings, at handovers and in the weekly multidisciplinary meetings. This enabled staff to focus on the current risks and review how effective management and mitigation plans were working. All care records for patients had up-to-date risk assessments.

Staff identified and responded to any changes in risks to, or posed by, patients, for example where required additional observations were carried out, or additional staff rostered on shift.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff followed 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 and/or reducing. None of the patients we spoke to had been restrained or witnessed any restraints during their admission.

Staff participated in the service'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, for example we observed prompt positive interaction by a support worker when a patient had become agitated and distressed. The staff member was calm, listened to the patient and responded appropriately.

Staff had been successful in practices of de-escalation with patients and prevented the need for more invasive interventions.

In the 12 months before the inspection there had been 12 incidents involving restraint, two of which had involved restraint in the prone position. There had been two incidents requiring the use of rapid tranquilisation and no incidents of seclusion. Staff followed National Institute of Health and Care Excellence guidance when using rapid tranquilisation. Staff described the physical health checks they carried out on patients post rapid tranquilisation.

All incidents of restraint, seclusion and rapid tranquilisation were reviewed at the clinical governance meeting. Managers and the security lead were also able to access CCTV footage from communal areas to review incidents of restraint.

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.

Good

Forensic inpatient or secure wards

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff said they felt confident in reporting safeguarding alerts and knew how to make a safeguarding referral and who to inform if they had concerns.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff we spoke to had all received safeguarding training which was up to date. They told us they knew how to recognise and report incidents of abuse and felt confident in doing so. Staff reported that regularly discussed safeguarding concerns within the multidisciplinary team and daily handover meetings.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The social worker and clinical manager met regularly with local authority safeguarding leads to discuss any outstanding safeguarding cases and raise issues of concern with them. The hospital told us they had experienced challenges getting final outcomes for s42 enquiries and that they were working closely with the local authority to resolve this issue.

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.

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Patient notes were comprehensive, and all staff could access them easily. Records were stored securely.

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.

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health at the weekly multidisciplinary team meeting. Systems were in place to check controlled drugs.

The pharmacist carried out weekly visits and undertook weekly medicine audits. The pharmacy provided a 'live' chat function and any issues were discussed with the service promptly. Results of the audits were sent to the service and any shortfalls were discussed at the integrated governance meeting. Any medicine incidents including errors were reviewed monthly by the medical director and the clinical nurse manager.

Staff regularly reviewed the effects of medicines on each patient's mental and physical health in line with guidance from the National Institute of Health and Care Excellence. Where staff administered 'as required' medicines staff carried out regular observations to ensure the patient was safe.

Track record on safety

The service had a good track record on safety.

Good

Forensic inpatient or secure wards

The service had a good track record on safety.

The service had 29 serious incidents in the previous 12 months.

These incidents were investigated, and lessons learned were shared with the staff team.

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.

The service managed patient safety incidents well. All staff knew what incidents to report and how to report them using the electronic incident reporting system. Staff told us that they would report any incident of harm, potential harm and/or risks to safety.

At our inspection in April 2018, lessons learnt from incidents, complaints and safeguarding concerns were not shared with all staff teams. Staff teams did not have opportunities to reflect on their work collectively. At this inspection we found improvements. Staff received feedback from investigation of incidents, both internal and external to the service.

Staff told us incidents and never events were discussed in handover, multidisciplinary team meetings, in reflective practice, supervision and staff meetings. Learning from incidents was now a standing agenda item for the monthly team meeting. Incidents were also discussed at clinical governance meetings with attendees passing on learning to their respective teams

All incidents were analysed and any themes and trends discussed with the staff team.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Duty of candour incidents were reviewed and discussed at the monthly integrated clinical governance meetings.

Managers investigated incidents thoroughly and in a timely, for example following a serious security breach the service commissioned an independent review of the security arrangements within the hospital, an action plan had been developed to follow up on issues identified so that improvements could be made to the security arrangements within the hospital.

Managers debriefed and supported staff after any serious incident. Staff felt well supported and were offered the opportunity to debrief immediately following incidents and also in regular reflective practice sessions. The hospital was also trialling a new programme of supporting staff wellbeing following incidents called Trauma Risk Management (TRiM) a trauma-focused peer support system designed to help staff who have experienced a traumatic, or potentially traumatic, event. The hospital also had a Sustaining Resilience at Work (STRaW) practitioner who visited the site two days per week to offer support to all staff.

There was evidence that changes had been made as a result of feedback, for example, changes had been made to search procedures as patients had been able to bring contraband items onto the ward. Staff had undertaken additional relational security training.

Good

Forensic inpatient or secure wards

All patients were subject to random and routine body or room searches, subject to risk assessment

Are Forensic inpatient or secure wards effective?

Good

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

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. They included specific safety and security arrangements and a positive behavioural support plan.

The service assessed patients before they were admitted to check they were suitable for admission. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff supported patients with their physical health needs and worked collaboratively with specialists when needed. Staff registered patients with a local GP upon admission for their primary care. Ward doctors also assessed and addressed patients' physical health and liaised with the GP when required.

Plans for on-going monitoring of health conditions such as diabetes and hypertension and healthcare investigations were developed. This included close and regular monitoring of blood samples, heart rate, pulse, urine tests, temperature, weight monitoring and electrocardiogram (ECG). Where patient refused to engage with physical health assessments this was clearly recorded.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Care plans were personalised, holistic and recovery orientated. They reflected the assessed needs of the patient. Staff regularly reviewed and updated care plans when patients' needs changed.

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.

Staff provided a range of care and treatment suitable for the patients in the service. Patients had access to medicines, psychological therapies, activities, community access and integration and life skills development.

Good

Forensic inpatient or secure wards

Staff delivered care in line with best practice and national guidance, for example, the activity timetable was put together using guidance from Royal College of Occupational Therapy (RCOT), Fit for Work, Recovery College guidance in addition to National Institute for Health and Care Excellence guidelines.

Staff identified patients' physical health needs and recorded them in their care plans.

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

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The service made dietary adjustments for patients' religious, cultural and other needs.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The occupational therapy team offered activities targeted toward patient's wellbeing for example, relaxation and mindfulness, smoking cessation, fitness group, table tennis, healthy snack preparation and men's wellbeing. The ward occupational therapist undertook a health screen with all new patients and one member of the occupational therapy team was training to be a fitness instructor and hoped to incorporate this into their work by supporting patients to develop individual fitness plans.

Staff supported patients with their recovery goals. Some patients undertook paid ward jobs such as the ward also operated a scheme to employ patients to assist in maintaining the kitchen used in occupational therapy sessions and to participate in the service user council.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff measured patients progress and the effectiveness of their treatment at each ward round and against individual recovery goals.

Staff used technology to support patients. Patients had access to computers and had their own passwords. This usage was monitored carefully but allowed patients to make use of accessing the internet in a safe way. The hospital used an online care model called 'my Path'. This monitored patient engagement levels, care planning, progress monitoring and outcome measures and was evaluated through clinical and governance frameworks within the hospital.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements, by implementing and monitoring action plans.

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 a full range of specialists to meet the needs of the patients on the ward. This included consultant psychiatrist, nursing staff, ward doctors, psychologists, occupational therapists and social worker. Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. The percentage of staff that had had an appraisal in the last 12 months was 93%. Medical staff appraisals were at 100%.

Good

Forensic inpatient or secure wards

At our inspection in April 2018, staff did not receive appropriate supervision. At this inspection we found improvements. All staff we spoke with confirmed they had access to regular supervision. They used supervision to discuss the current patients, to reflect and learn from practice, incidents and for personal support and professional development. Staff supervision records reflected these discussions.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Where staff were unable to attend team meeting minutes were available.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role, for example staff had started training in autism and *attention deficit hyperactivity disorder* (*ADHD*). The consultant psychiatrist on Tyler ward had specialist knowledge in this area and provided clinical input where required.

The service was in the process of recruiting a physical health lead nurse. The role included running physical health clinics, bloods, ECG's and health promotion work, annual physical health checks and support to the staff team.

Managers recognised poor performance, could identify the reasons and dealt with these through supervision and performance management plans.

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. All members of the multidisciplinary team and staff worked together to understand and meet the range and complexity of patient's needs. Patients were invited in to discuss their care and treatment and the room had access to a large screen linked to the hospital IT system so that external people could join the meeting. This meant family, carers and professionals had improved access which benefited the patient by supporting smoother discharge planning.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. The hospital had daily situation report meeting each morning which discussed staffing, incidents, referrals, admissions, planned discharges, diary appointments and any other relevant issues. These were well attended by managers and the wider clinical team. Each shift held a handover where incidents and patient care was discussed.

Staff worked effectively together and with other health and social care professionals to deliver effective care and treatment. Care co-ordinators regularly attended care programme approach meetings. Staff reported that they had good relationships with commissioners, local authority social services, local charities for vocational work and an online education platform.

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

Good

Forensic inpatient or secure wards

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.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. There was a dedicated advocate who visited the ward one day per week to support patients with tribunal hearings and complaints. The advocate told us that having keys to the ward and being able to spend time with the patients meant she was able to get to know them well which helped her to support them better.

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. Patients we spoke to told us they were able to take their leave.

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.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. The clinical manager reported that they worked in collaboration with other agencies, such as the local authority, care co-ordinators and commissioners to ensure that aftercare arrangements were in place prior to the patient being discharged.

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.

Good

Forensic inpatient or secure wards

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

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

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. Staff checked that patients had the mental capacity to consent to care and treatment at admission and at appropriate intervals.

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.

Are Forensic inpatient or secure wards caring?

Good

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

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.

The staff and management team spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and diverse needs.

Staff were discreet, respectful, and responsive when caring for patients. The interactions we observed between staff and patients were kind and respectful. Patients told us they felt they were treated with dignity and respect. Carers told us they found the staff to be caring and professional.

Staff gave patients help, emotional support and advice when they needed it. Patients told us they could speak to staff and that they felt listened to and supported.

Staff supported patients to understand and manage their own care treatment or condition. Patients were able to discuss their care and treatment during ward round meetings

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

Good

Forensic inpatient or secure wards

Patients said staff treated them well and behaved kindly. All patients told us they felt safe on the ward. We observed staff interactions with patients and found them to be calm and respectful.

Staff understood and respected the individual needs of each patient. They adapted their approach to each individual and worked with patients' individual preferences. Staff worked hard to understand patients' behaviour through debriefs and reflective practice. The psychology team worked with the multidisciplinary team to formulate support plans to enable to the wider team to support patients effectively.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff we spoke to told us they felt safe to raise any concerns if they had them. They were also aware of the freedom to speak up guardian and knew how to access this, should they need to

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. A comprehensive welcome pack was available and this provided information about the service. There was also further information on mutual expectations which had been updated at a recent away day and this included guidance on smart phones, trading and smoking breaks.

Patients were involved in developing and reviewing their care plans and risk assessments.

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 were able to attend a weekly community meeting and provided feedback on the service. Patients were part of staff interview panels such as recent occupational therapy recruitment.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients were also supported by the expert by experience team within the organisation and could attend the monthly patient's council meeting.

Staff made sure patients could access advocacy services. The independent advocate visited the ward one day per week to support patients with tribunal hearings and complaints. Advocacy and contact details were displayed throughout the ward.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Good

Forensic inpatient or secure wards

Staff supported, informed and involved families or carers as appropriate. The hospital held carer events, but these were not well attended due to many carers not living locally. The hospital also posted a quarterly newsletter to family and carers. This provided updates on the hospital, past and upcoming events and how families and carers could be involved. Carers told us that they were able to get through to the ward without difficulty, felt involved in their relatives' care and knew what was happening.

Staff provided carers with information about how to access a carer's assessment.

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. A lift was available for patients with mobility difficulties so they could access the ward.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The information provided was in a form accessible to the particular patient group according to each patient's needs. Staff made information leaflets available in languages spoken by patients if requested.

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

Patients had access to spiritual, religious and cultural support. Staff responded to individual requests for support as appropriate. A multi-faith room was available. Due to the COVID -19 pandemic staff had not been facilitating any onsite visits. Plans were in place to reintroduce these to the service with the easing of restrictions.

Are Forensic inpatient or secure wards responsive?

Good

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

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.

Bed management

The ward had a clear admission policy and criteria for admission that staff followed. All referrals were discussed within the multidisciplinary prior to admission. The multidisciplinary reviewed length of stay for patients to ensure they did not stay longer than they needed to. The service worked closely with the Ministry of Justice, commissioners and the local authority when planning patient discharge.

Good

Forensic inpatient or secure wards

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.

Staff did not move or discharge patients at night or very early in the morning. All transfers of care were managed to ensure they happened at the appropriate time for the patient and any moves to other units were based on clinical need and in the interest of patients.

Discharge and transfers of care

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. The ward held a weekly multidisciplinary meeting which was also used to plan patient discharges. Patients families and care coordinators were invited to join in person or remotely. Care co-ordinators were invited to care programme approach (CPA) meetings prior to discharge.

Managers monitored the number of delayed discharges. Delayed transfers were discussed at the senior leadership and clinical governance meetings. Each patient's progress was tracked. Delayed discharges related to challenges in finding an appropriate placement.

Staff planned for patients' discharge by involving patients, their family, carers and their care coordinators. Staff supported patients to visit different placements and arranged overnight leave, so that there was a smooth transition between the service and other placements.

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. Patients had somewhere secure to store their possessions. Each patient had a locker and a safe where they could store possessions.

Staff and patients had access to the 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.

Space was limited on the ward. A large room on the ward was used as a gym, an occupational therapy room and a meeting room. This meant that patients could not access the gym equipment or some occupational therapy activities when meetings were taking place.

All patients were able to make phone calls in private and had access to mobile telephones.

The service had an outside space that patients could access easily. Patients had unrestricted access to a small balcony and restricted access to a small garden. Patients could only use this garden with authorisation from their responsible clinician.

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food.

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. Patients accessed the providers recovery college and had access to educational and vocational courses. The occupational therapy department worked with Choice Support, a charity, to support patients identify vocational opportunities to develop their independent living skills. The hospital also works with Future Learn an online educational platform to support patients access to education opportunities.

Staff helped patients to stay in contact with families and carers. Patients could speak to their family on their own mobile phones. Some patients reported that the hospital was far away for their family members to visit and that the visiting policy was too restrictive in requesting 24-hour notice of planned visits.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

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. A lift was available for patients with mobility difficulties so they could access the ward. All bathroom and garden areas were accessible for patients with limited mobility.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The information provided was in a form accessible to the particular patient group according to each patient's needs. Staff made information leaflets available in languages spoken by patients if requested.

Managers made sure staff and patients could get help from interpreters or signers where the first persons language was not English.

Patients had access to spiritual, religious and cultural support. Staff responded to individual requests for support. Patients could access a multifaith room on the ward.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. Patients and carers we spoke with understood how to make a complaint and told us they would feel comfortable doing so.

The service clearly displayed information about how to raise a concern in patient areas. The patient information pack contained information about how to make a complaint. Complaint posters were displayed throughout the ward.

Good

Forensic inpatient or secure wards

Staff understood the policy on complaints and knew how to handle them. Staff we spoke to understand the complaints process and supported patients to make complaints and feedback about the service.

Managers investigated complaints and identified themes. All complaints were discussed at the clinical monthly clinical governance meetings and any themes or trends identified shared with the wider organisation.

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

Staff knew how to acknowledge complaints and 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. Staff told us complaints were discussed in handovers, clinical governance and staff meetings, this information was used to inform patient care. The service used compliments to learn, celebrate success and improve the quality of care. We saw completed compliment forms praising housekeeping staff for the cleanliness of the ward and compliments about the quality of food provision.

Are Forensic inpatient or secure wards well-led?

Good

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. The registered manager had been in the post since March 2021. The registered manager was a registered nurse. They had experience of working in forensic and PICU settings.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. During our inspection the registered manager demonstrated a good understanding of patients, the staff team and all matters relating to the provision of psychiatric intensive care services.

Leaders were visible in the service, approachable and accessible for patients and staff.

Staff reported they could raise any concerns they had with them. Staff praised the registered manager for being open, transparent and supportive. They told us that they were open to new ideas and ways of working.

Leadership development opportunities were available, including opportunities for staff below team manager level.

The manager supported staff to develop their skills and take on more senior roles, for example on each ward a member of staff had undertaken training in trauma risk management.

Vision and strategy

Good

Forensic inpatient or secure wards

Staff knew and understood the provider's strategy, vision and values and how they were applied in the work of their team. Staff promoted the five values of the organisation which included integrity, trust, empower, respect and care. Throughout our inspection we saw that staff reflected these values in their daily practice. The service had a caring, positive, open and inclusive culture which centred on improving the quality of care patients received through, compassion, empowerment, partnership and involvement.

Culture

Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear of retribution and that any concerns they raised were acknowledged and taken seriously by senior managers.

Staff reported the morale on the ward was improving and there had been a significant change within the culture of the hospital with the new registered manager.

Staff described the registered manager as having an 'open door' policy, being accessible, open and transparent. Staff were encouraged to share their views.

Staff felt positive and proud about working for their ward team. They felt supported by the team and felt the team worked well together. Staff gave examples of how they had pulled together during COVID-19 and become more effective as a team. Staff told us they valued each other.

The whistleblowing policy was easily available for staff to access on the intranet system. Staff were aware of the organisations freedom to speak up guardian and how to contact them.

Managers dealt with poor staff performance appropriately when needed. Performance issues were initially addressed during to one-to-one supervision sessions and goals and objectives were introduced for staff whose performance needed to be improved.

Staff had access to support for their own physical and emotional health needs. The organisation provided an employee assistance programme where staff could access counselling, legal and financial advice. Staff also accessed the providers occupational health services when needed.

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. The provider had addressed the actions we made at our previous inspections.

Governance and performance monitoring arrangements were in place to support the delivery of the service, identified risk and monitored the quality and safety of service provision. There were systems and procedures to ensure that the ward was clean and safe. Environmental works were planned for including a fully functioning patient call alarm system. There were sufficient staff on duty to meet the assessed needs of patients safely and additional staff could be rostered if needed. Staff were trained, supervised and appraised appropriately. Staff ensured patient outcomes and clinical effectiveness.

Good

Forensic inpatient or secure wards

The registered manager and senior leadership team were aware of areas where improvements could be made and were committed to improving care and treatment for patients. They knew that improvements in the service needed to be embedded and sustained.

There was a clear framework for communication, this enabled staff to be kept updated about the service, incidents, safeguarding, complaints and essential information through regular team, clinical governance, and daily hospital meetings. Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. Regular audits were carried out and action plans developed where shortfalls had been identified.

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 an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Staff were aware of the main risks in relation to the service they were providing. Each ward had a risk register which fed into the service risk register. Staff could participate in discussions about entries. The risk register was reviewed at the weekly senior leadership meeting.

The service had plans for emergencies. Staff spoke about the business continuity plans they had implemented as a result of the COVID-19 pandemic.

Information management

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The service had a dashboard that held key data about the service. This included key information such as incident reporting, staffing, complaints and training.

Engagement

Staff received regular updates about the work of the provider through My Cygnet intranet, regular newsletters, emails, social media and updates at the team meeting. The provider had a comprehensive website and social media to keep the public informed of the work they were undertaking to support patients, families and carers.

The service engaged well with patients, carers and staff to help them plan and manage the way the service operated. Staff had participated in the annual Cygnet staff survey in April 2021. The service had developed and implemented an action plan in response to the service and was addressing areas such as resilience training. access to the multi-cultural networking group and flexible working.

Feedback was encouraged, and people were supported to provide feedback in a way that was best for them. Patients could give feedback through weekly community meetings, patient forums, patient council meetings and through their local advocacy service. We saw examples where managers had used patient, staff or carer feedback to make improvements to the service such as the service purchasing a portable ECG machine following a patient complaint.

Staff confirmed that some patients had been trained and had participated in staff interview panels.

Good

Forensic inpatient or secure wards

Staff were supported to progress. A member of the occupational therapy team was training to be a fitness instructor, another staff member had completed their leadership and development course. Opportunities for trainee nursing associates were available through an apprenticeship scheme.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. The hospital was trialling a new programme of supporting staff wellbeing following incidents called Trauma Risk Management (TRiM) a trauma-focused peer support system designed to help staff who have experienced a traumatic, or potentially traumatic, event. Staff involved in this programme had been trained by a psychological health consultancy.

The ward was a member of the Royal College of Psychiatry Network for forensic mental health services. Staff working at the service took part in peer reviews of similar wards and explained how they learned from these reviews and implemented good practice on their own ward.

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 because:

Safe and clean care environments

The ward was safe, clean, well equipped, furnished, maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all wards areas and removed or reduced any risks they identified. Staff carried out a health and safety check of the ward environment on each shift.

The ward layout allowed staff to observe all parts of the ward. Closed circuit television (CCTV) was in place in the corridors and communal areas and recorded any activity taking place. Staff carried out regular observations to manage patient risk.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe, for example, by using observation, engagement and individual risk management plans for each patient. A ligature audit had been carried out in March 2021 which included photographs of ligature points. A ligature heat map was on display in the nurse's office. As part of the ward refurbishment programme plans were in place to replace bedroom doors, radiator covers and install night lighting.

The ward complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms. Patients did not have access to the nurse call system. This system had been disabled. There had been a corporate review of nurse call systems across all Cygnet Hospital sites and we saw that works were due to take place to install a new patient call system throughout the hospital by the end of 2021. The registered manager reported that there had been delays in contractors visiting the hospital to carry out a full review because of the COVID -19 pandemic. Where patients, were assessed as requiring the use of a nurse call bell, management plans were put in place such as enhanced observations.

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

Good

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. An environmental action plan was in place and this detailed the works planned for the ward which included redecoration, new flooring, new furniture and new bedroom doors. The estates team met monthly where any maintenance and estates issues were discussed, actions agreed and any issues escalated to senior management.

Staff made sure cleaning records were up-to-date and the premises were clean. Housekeeping staff were seen cleaning high touch areas throughout the day.

Staff followed infection control principles including appropriate handwashing techniques, use of personal protective equipment (PPE) including aprons, masks, gloves, and hand sanitiser was readily available. Staff accessed infection control training. Training was compliant at 93%. The clinical nurse manager was also the infection prevention control lead for the hospital.

Regular infection control and handwashing audits took place. The ward scored 98% at the August 2021 audit. Where any improvements were required these were shared at the team and clinical governance meetings.

Seclusion room

At the time of the inspection the seclusion room on the ward was not in use as it had been damaged by a patient. Works to repair the damage were in progress. The seclusion room allowed clear observation and two-way communication. It had a toilet, shower and a clock.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked daily. The clinic room was well ordered, clean and tidy. Staff checked, maintained, and cleaned equipment. Staff ensured that equipment was correctly calibrated. Checks were being carried out regularly and where there were any gaps these were addressed by the ward manager.

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 staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The service had enough nursing and support staff to keep patients safe and to provide the right care and treatment. Staffing was reviewed daily with the senior management team and for the following 24hrs within the daily situation report meeting. The ward had appointed two night-time team leaders to support the staff team.

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

Good

The ward had vacancies for three registered nurses and six health care assistants. The service was actively recruiting into vacant posts. This included undertaking recruitment overseas. The service had reduced its use of agency staff. Staffing levels were maintained by the deployment of bank staff mainly and where required agency staff.

Where bank and agency staff were used these staff received an induction and were familiar with the ward.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The service used a staffing matrix which determined the numbers of staff required dependent on the number of patients and their acuity.

The ward manager could adjust staffing levels according to the needs of the patients, for example an additional member of staff had been agreed for each shift following discussion with the hospital manager.

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

Patients rarely had their escorted leave cancelled, even when the service was short staffed. Patients we spoke to told us they had access to activities. For example, cooking sessions, table tennis and access to a gaming console. However, some patients told us that activities planned in the evening and at the weekend often did not happen.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others, for example, sitrep meetings were held daily as well as handover meetings between shifts. Staff told us they used these meetings to discuss any incidents that had occurred and update patient risk information.

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. Patients were seen and monitored in a timely way. The service operated an on-call system for out of hours.

Managers could call locums when they needed additional medical cover.

Mandatory training

Staff had completed and mostly kept up to date with their mandatory training to ensure they had the appropriate knowledge and skills to carry out their roles safely. Overall compliance for Tyler ward was at 97%. The provider had not managed compliance with basic life support which was at 66%. Compliance for intermediate life support training was 100%. Training compliance and where improvements were required were discussed at the monthly integrated governance meeting.

The service was gradually resuming face to face training in accordance with changes in COVID restrictions. We saw that training had been booked for staff that required basic life support training for their role. The hospital manager reported that there were backlogs with face to face such as basic life support due to the COVID-19 pandemic.

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

Good

The mandatory training was comprehensive and met the needs of patients and staff. Staff we spoke with said they felt confident carrying out their role and applied training to their practice. They were fully supported to carry out any additional required training. 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

Staff completed risk assessments for each patient on admission using a recognised tool. Risk assessments were reviewed regularly, including after any incident. The psychology department took a lead in patient risk assessments and used a range of evidence-based tools such as Structured Assessment of Protective Factors (SAPROF), short term assessment of risk and treatability (START) and Historical Clinical Risk Management-20 (HCR-20).

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. All staff we spoke with had a good understanding of each patient and the risks they posed. Patient risk assessment and management was discussed in the daily situation report meetings, at handovers and in the weekly multidisciplinary meetings. This enabled staff to focus on the current risks and review how effective management and mitigation plans were working. All care records for patients had up-to-date risk assessments.

Staff identified and responded to any changes in risks to, or posed by, patients, for example where required additional observations were carried out, or additional staff rostered on shift.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Staff participated in the service'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.

Staff had been successful in practices of de-escalation with patients and prevented the need for more invasive interventions. None of the patients we spoke to had been restrained during their admission. A patient described how they had seen staff talking to patients using de-escalation techniques as opposed to physically restraining them.

In the 12 months before the inspection there had been 53 incidents involving restraint, 21 of which had involved restraint in the prone position. There had been 22 incidents requiring the use of rapid tranquilisation and 22 incidents of seclusion. Staff followed National Institute of Health and Care Excellence guidance when using rapid tranquilisation. Staff described the physical health checks they carried out on patients post rapid tranquilisation.

All incidents of restraint, seclusion and rapid tranquilisation were reviewed at the clinical governance meeting. Managers and the security lead were also able to access CCTV footage from communal areas to review incidents of restraint.

Safeguarding

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff said they felt confident in reporting safeguarding alerts and knew how to make a safeguarding referral and who to inform if they had concerns.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff we spoke to had all received safeguarding training which was up to date. They told us they knew how to recognise and report incidents of abuse and felt confident in doing so. Staff reported that regularly discussed safeguarding concerns within the multidisciplinary team and daily handover meetings.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act, for example, a patient who was vulnerable due to their sexuality met regularly with the social worker to ensure that they felt safe on the ward.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The social worker and clinical manager met regularly with local authority safeguarding leads to discuss any outstanding safeguarding cases and raise issues of concern with them. The hospital told us they had experienced challenges getting final outcomes for s42 enquiries and that they were working closely with the local authority to resolve this issue.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health at the weekly multidisciplinary team meeting. Systems were in place to check controlled drugs.

The pharmacist carried out weekly visits and undertook weekly medicine audits. The pharmacy provided a 'live' chat function and any issues were discussed with the service promptly. Results of the audits were sent to the service and any shortfalls were discussed at the integrated governance meeting. Any medicine incidents including errors were reviewed monthly by the medical director and the clinical nurse manager.

Staff regularly reviewed the effects of medicines on each patient's mental and physical health in line with guidance from the National Institute of Health and Care Excellence.

Track record on safety

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

Good

The service had a good track record on safety.

The service had 29 serious incidents in the previous 12 months.

These incidents were investigated, and lessons learned were shared with the staff team.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. All staff knew what incidents to report and how to report them using the electronic incident reporting system. Staff told us that they would report any incident of harm, potential harm and/or risks to safety.

At our inspection in April 2018, lessons learnt from incidents, complaints and safeguarding concerns were not shared with all staff teams. Staff teams did not have opportunities to reflect on their work collectively. At this inspection we found improvements. Staff received feedback from investigation of incidents, both internal and external to the service.

Staff told us incidents and never events were discussed in handover, multidisciplinary team meetings, in reflective practice, supervision and staff meetings. Learning from incidents was now a standing agenda item for the monthly team meeting. Incidents were also discussed at clinical governance meetings with attendees passing on learning to their respective teams

All incidents were analysed and any themes and trends discussed with the staff team.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Duty of candour incidents were reviewed and discussed at the monthly integrated clinical governance meetings.

Managers investigated incidents thoroughly and in a timely, for example following a serious security breach the service commissioned an independent review of all the security arrangements within the hospital.

Managers debriefed and supported staff after any serious incident. Staff felt well supported and were offered the opportunity to debrief immediately following incidents and also in regular reflective practice sessions. The hospital was also trialling a new programme of supporting staff wellbeing following incidents called Trauma Risk Management (TRiM) a trauma-focused peer support system designed to help staff who have experienced a traumatic, or potentially traumatic, event. The hospital also had a Sustaining Resilience at Work (STRaW) practitioner who visited the site two days per week to offer support to all staff.

There was evidence that changes had been made as a result of feedback, for example, the ward manager had introduced the smart phone initiative. Patients are expected to hand in their smart phones when first admitted. The use of a smart phone is then risk assessed at their first ward round and they are then allowed access to them daily from 3pm until 10pm. This allowed patients time to engage in ward therapy but also make use of their phones. This pilot had been successful, and learning has been shared across the Cygnet PICU network.

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

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

Good

Good

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

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.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff supported patients with their physical health needs and worked collaboratively with specialists when needed. Where patient refused to engage with physical health assessments this was clearly recorded.

Plans for on-going monitoring of health conditions and healthcare investigations were developed. This included close and regular monitoring of blood samples, heart rate, pulse, urine tests, temperature, weight monitoring and electrocardiogram (ECG).

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Care plans were personalised, holistic and recovery orientated. They reflected the assessed needs of the patient. Staff regularly reviewed and updated care plans when patients' needs changed.

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.

Staff provided a range of care and treatment suitable for the patients in the service. Patients had access to medicines, psychological therapies, activities.

Staff delivered care in line with best practice and national guidance, for example, the activity timetable was put together using guidance from Royal College of Occupational Therapy (RCOT), Fit for Work, Recovery College guidance in addition to National Institute for Health and Care Excellence guidelines.

Staff identified patients' physical health needs and recorded them in their care plans.

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

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The service made dietary adjustments for patients' religious, cultural and other needs.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The occupational therapy team offered activities targeted toward patient's wellbeing for example, relaxation and mindfulness, smoking cessation, fitness group, table tennis, healthy snack preparation and men's wellbeing. The ward occupational therapist undertook a health screen with all new patients and one member of the occupational therapy team was training to be a fitness instructor and hoped to incorporate this into their work by supporting patients to develop individual fitness plans.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. They used the findings to make improvements and achieved good outcomes for patients.

Staff used technology to support patients. Patients had access to computers and had their own passwords. This usage was monitored carefully but allowed patients to make use of accessing the internet in a safe way.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements, by implementing and monitoring action plans.

Skilled staff to deliver care

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

The service had a full range of specialists to meet the needs of the patients on the ward. This included consultant psychiatrist, nursing staff, ward doctors, psychologists, occupational therapists and social worker. Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. The percentage of staff that had had an appraisal in the last 12 months was 86%. Medical staff appraisals were at 100%.

At our inspection in April 2018, staff did not receive appropriate supervision. At this inspection we found improvements. All staff we spoke with confirmed they had access to regular supervision. They used supervision to discuss the current patients, to reflect and learn from practice, incidents and for personal support and professional development. Staff supervision records reflected these discussions.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Where staff were unable to attend team meeting minutes were available.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role, for example staff had started training in autism and attention deficit hyperactivity disorder (ADHD). The consultant psychiatrist on Tyler ward had a specialist interest in this area and was available to staff for training and advice.

The service was in the process of recruiting a physical health lead nurse. The role included running physical health clinics, bloods, ECG's and health promotion work, annual physical health checks and support to the staff team.

Managers recognised poor performance, could identify the reasons and dealt with these through supervision and performance management plans.

Multidisciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with 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. All members of the multidisciplinary team and staff worked together to understand and meet the range and complexity of patient's needs. Patients were invited in to discuss their care and treatment and the room had access to a large screen linked to the hospital IT system so that external people could join the meeting. This meant family, carers and professionals had improved access which benefited the patient by supporting smoother discharge planning.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. The hospital had daily situation report meetings each morning which discussed staffing, incidents, referrals, admissions, planned discharges, diary appointments and any other relevant issues. These were well attended by managers and the wider clinical team. Each shift held a handover where incidents, patient care and risk were discussed.

Staff worked effectively together and with other health and social care professionals to deliver effective care and treatment. Care co-ordinators regularly attended care programme approach meetings. Staff reported that they had good relationships with commissioners, local authority social services, local charities for vocational work and an online education platform.

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.

At our inspection in 2018, we found medicine errors relating to compliance with the Mental Health Act 1983. This meant that some medicines had been prescribed unlawfully. At this inspection we found improvements. Weekly medicine audits were carried out to check that medicines had been prescribed lawfully. Any issues were discussed at the integrated governance meeting and compliance with the Mental Health Act and medicines treatment were monitored through the Medical Advisory Committee.

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.

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

Good

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. There was a dedicated advocate who visited the ward one day per week to support patients with tribunal hearings and complaints. The advocate told us that having keys to the ward and being able to spend time with the patients meant she was able to get to know them well which helped her to support them better.

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. Patients we spoke to told us they were able to take their leave.

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.

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.

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

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

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. Staff checked that patients had the mental capacity to consent to care and treatment at admission and at appropriate intervals.

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.

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

Good

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

Good

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

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.

The staff and management team spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and diverse needs.

Staff were discreet, respectful, and responsive when caring for patients. The interactions we observed between staff and patients were kind and respectful. Patients told us they felt they were treated with dignity and respect.

Staff gave patients help, emotional support and advice when they needed it. Patients told us they could speak to staff and that they felt listened to and supported.

Staff supported patients to understand and manage their own care treatment or condition. Patients were able to discuss their care and treatment during ward round meetings

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. All patients told us they felt safe on the ward. We observed staff interactions with patients and found them to be calm and respectful.

Staff understood and respected the individual needs of each patient. They adapted their approach to each individual and worked with patients' individual preferences. Staff worked hard to understand patients' behaviour through debriefs and reflective practice. The psychology team worked with the multidisciplinary team to formulate support plans to enable to the wider team to support patients effectively.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff we spoke to told us they felt safe to raise any concerns if they had them. They were also aware of the freedom to speak up guardian and knew how to access this, should they need to.

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.

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

Good

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. A comprehensive welcome pack was available and this provided information about the service.

Patients were involved in developing and reviewing their care plans and risk assessments. However, two out four patients told us they did not have copies of their care plan.

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 were able to attend a weekly community meeting and provided feedback on the service. Patients were part of staff interview panels such as recent occupational therapy recruitment.

Patients could give feedback on the service and their treatment and staff supported them to do this, for example, patients had completed a survey on activities and therapies. The results were used to formulate a new timetable and activities on the ward. Patients were also supported by the expert by experience team within the organisation and could attend the monthly patient's council meeting.

Staff made sure patients could access advocacy services. The independent advocate visited the ward one day per week. Advocacy and contact details were displayed throughout the ward.

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

Patients had access to spiritual, religious and cultural support. Staff responded to individual requests for support as appropriate.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers as appropriate. The hospital held carer events, but these were not well attended due to many carers not living locally. The hospital also posted a quarterly newsletter to family and carers. This provided updates on the hospital, past and upcoming events and how families and carers could be involved.

Staff provided carers with information about how to access a carer's assessment.

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 because:

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

Good

Access and discharge

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

The ward had a clear admission policy and criteria for admission that staff followed. All referrals were discussed within the multidisciplinary. At the time of the inspection the service was not taking any patients that required seclusion due to the seclusion room being renovated following damage. Staff told us that if a patient required seclusion that seclusion room on Meridian ward would be used.

The multidisciplinary reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay for patients on the ward was two months. Where patients no longer required PICU services the team worked with commissioners for patients to be moved back to their catchment area. The ward took referrals from all parts of the United Kingdom, most patients were out of area placements.

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.

Staff did not move or discharge patients at night or very early in the morning. All transfers of care were managed to ensure they happened at the appropriate time for the patient and any moves to other units were based on clinical need and in the interest of patients.

Discharge and transfers of care

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. The ward held a weekly multidisciplinary meeting which was also used to plan patient discharges. We observed discussion around a patient's discharge including which discharge pathway was most suitable for them. Patients families and care coordinators were invited to join in person or remotely. Care co-ordinators were invited to care programme approach (CPA) meetings prior to discharge.

Managers monitored the number of delayed discharges. Delayed transfers were discussed at the senior leadership and clinical governance meetings. Each patient's progress was tracked.

Managers had a delayed transfer of care spreadsheet which they used to monitor and keep a record of progress with discharges.

Staff actively worked with commissioners to improve the timeliness of discharge. The hospital manager reported that delays occurred when an acute admission bed was not available in the patient's local area.

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. 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. All bedrooms had an en-suite bathroom. Staff stored patients' personal possessions securely.

There was limited space on the ward to carry out patient activities. The occupational therapy room on the ward was also the room used for weekly ward rounds, for tribunals, Mental Health Act assessments and care programme approach meetings. The lack of space sometimes impacted on the number of patient groups/activities that could be run.

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

All patients were able to make phone calls in private and had access to mobile telephones.

The service had an outside space that patients could access easily. Patients had unrestricted access to a small balcony and restricted access to a small garden. Patients could only use this garden with authorisation from their responsible clinician.

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food. Community meeting minutes showed patients were very happy with the food offered. One patient had submitted a compliment form praising the food choice, flavour and quality as good. Another patient followed a halal diet and told us the food was very good.

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 occupational therapy department worked with Choice Support, a charity, to support patients identify vocational opportunities to develop their independent living skills. The hospital also works with Future Learn an online educational platform to support patients access to education opportunities.

Staff helped patients to stay in contact with families and carers. Patients could speak to their family on their own mobile phones. Some patients reported that the hospital was far away for their family members to visit and that the visiting policy was too restrictive in requesting 24-hour notice of planned visits.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

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. A lift was available for patients with mobility difficulties so they could access the ward. All bathroom and garden areas were accessible for patients with limited mobility.

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

Good

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The information provided was in a form accessible to the particular patient group according to each patient's needs. Staff made information leaflets available in languages spoken by patients if requested.

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

Patients had access to spiritual, religious and cultural support. Staff responded to individual requests for support.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. Patients and carers we spoke with understood how to make a complaint and told us they would feel comfortable doing so.

The service clearly displayed information about how to raise a concern in patient areas. The patient information pack contained information about how to make a complaint. Complaint posters were displayed throughout the ward.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke to understand the complaints process and supported patients to make complaints and feedback about the service.

Managers investigated complaints and identified themes. All complaints were discussed at the clinical monthly clinical governance meetings and any themes or trends identified shared with the wider team.

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

Staff knew how to acknowledge complaints and 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. Staff told us complaints were discussed in handovers, clinical governance and staff meetings, this information was used to inform patient care.

The service used compliments to learn, celebrate success and improve the quality of care. We saw completed compliment forms praising housekeeping staff for the cleanliness of the ward and compliments about the quality of food provision.

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

Good

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

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

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles. The registered manager had been in the post since March 2021. The registered manager was a registered nurse. They had experience of working in forensic and PICU settings.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. During our inspection the registered manager demonstrated a good understanding of patients, the staff team and all matters relating to the provision of psychiatric intensive care services.

Leaders were visible in the service, approachable and accessible for patients and staff.

Staff reported they could raise any concerns they had with them. Staff praised the registered manager for being open, transparent and supportive. They told us that they were open to new ideas and ways of working.

Leadership development opportunities were available, including opportunities for staff below team manager level.

The manager supported staff to develop their skills and take on more senior roles, for example on each ward a member of staff had undertaken training in trauma risk management.

Vision and strategy

Staff knew and understood the provider's strategy, vision and values and how they were applied in the work of their team. Staff promoted the five values of the organisation which included integrity, trust, empower, respect and care. Throughout our inspection we saw that staff reflected these values in their daily practice. The service had a caring, positive, open and inclusive culture which centred on improving the quality of care patients received through, compassion, empowerment, partnership and involvement.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider had a mission, vision and strategy alongside five values that they promoted including integrity, trust, empower, respect and care.

Culture

Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear of retribution and that any concerns they raised were acknowledged and taken seriously by senior managers.

Staff reported the morale on the ward was improving and there had been a significant change within the culture of the hospital with the new registered manager.

Staff described the registered manager as having an 'open door' policy, being accessible, open and transparent. Staff were encouraged to share their views.

Staff felt positive and proud about working for their ward team. They felt supported by the team and felt the team worked well together. Staff gave examples of how they had pulled together during COVID-19 and become more effective as a team. Staff told us they valued each other.

The whistleblowing policy was easily available for staff to access on the intranet system. Staff were aware of the organisations freedom to speak up guardian and how to contact them.

Managers dealt with poor staff performance appropriately when needed. Performance issues were initially addressed during to one-to-one supervision sessions and goals and objectives were introduced for staff whose performance needed to be improved.

Staff had access to support for their own physical and emotional health needs. The organisation provided an employee assistance programme where staff could access counselling, legal and financial advice. Staff also accessed the providers occupational health services when needed.

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. The provider had addressed the actions we made at our previous inspections.

Governance and performance monitoring arrangements were in place to support the delivery of the service, identified risk and monitored the quality and safety of service provision. There were systems and procedures to ensure that the ward was clean and safe. Environmental works were planned for including a fully functioning patient call alarm system. There were sufficient staff on duty to meet the assessed needs of patients safely and additional staff could be rostered if needed. Staff were trained, supervised and appraised appropriately. Staff ensured patient outcomes and clinical effectiveness.

The registered manager and senior leadership team were aware of areas where improvements could be made and were committed to improving care and treatment for patients. They knew that improvements in the service needed to be embedded and sustained.

There was a clear framework for communication, this enabled staff to be kept updated about the service, incidents, safeguarding, complaints and essential information through regular team, clinical governance, and daily hospital situation report meetings. Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. Regular audits were carried out and action plans developed where shortfalls had been identified.

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 an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Staff were aware of the main risks in relation to the service they were providing. Each ward had a risk register which fed into the service risk register. Staff could participate in discussions about entries. The risk register was reviewed at the weekly senior leadership meeting.

The service had plans for emergencies. Staff spoke about the business continuity plans they had implemented as a result of the COVID-19 pandemic.

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

Good

Information management

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The service had a dashboard that held key data about the service. This included key information such as incident reporting, staffing, complaints and training.

Engagement

Staff received regular updates about the work of the provider through My Cygnet intranet, regular newsletters, emails, social media and updates at the team meeting. The provider had a comprehensive website and social media to keep the public informed of the work they were undertaking to support patients, families and carers.

The service engaged well with patients, carers and staff to help them plan and manage the way the service operated. Staff had participated in the annual Cygnet staff survey in April 2021. The service had developed and implemented an action plan in response to the service and was addressing areas such as resilience training. access to the multi-cultural networking group and flexible working.

Feedback was encouraged, and people were supported to provide feedback in a way that was best for them. Patients could give feedback through weekly community meetings, patient forums, patient council meetings and through their local advocacy service.

Staff confirmed that some patients had been trained and had participated in staff interview panels.

Staff were supported to progress. A member of the occupational therapy team was training to be a fitness instructor, another staff member had completed their leadership and development course. Opportunities for trainee nursing associates were available through an apprenticeship scheme.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. The hospital was trialling a new programme of supporting staff wellbeing following incidents called Trauma Risk Management (TRiM) a trauma-focused peer support system designed to help staff who have experienced a traumatic, or potentially traumatic, event. Staff involved in this programme had been trained by a psychological health consultancy.