

Cygnet Hospital Woking

Quality Report

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

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Hospital Woking as Good because:

- There were enough suitably qualified and trained staff to provide care to a safe standard. Skilled staff delivered care and treatment. Throughout the two wards, the multidisciplinary team was consistently and pro-actively involved in patient care and everyone's contribution was considered of equal value. The staff were kind, caring and motivated and we saw good, professional and respectful interactions between staff and patients during our inspection.
- Patients' risk assessments and plans were robust, recovery focused and person centred. The assessment of patients' needs and the planning of their care was thorough, individualised and had a focus on recovery. Staff considered the needs of patients at all times. Physical healthcare assessments and associated plans of care were thorough and consistently delivered to a high standard.
- Patients had access to a variety of psychological therapies described as best practice in The National Institute for Health and Care Excellence guidance. This therapy was delivered either on a one-to-one basis or in a group setting, as part of the treatment programme. There was a varied, strong and recovery-orientated programme of therapeutic activities and treatment groups available every week.
- There was evidence of best practice in, and all staff had a good understanding of, the Mental Health Act 1983 (MHA), the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and the associated Codes of Practice.
- There were many examples of initiatives implemented to involve patients in their care and treatment. Patients told us that the staff consistently asked them for feedback about the service and how improvements could be made. Patients were appointed as ward

representatives and a 'people's council' met regularly and ensured good communication between patients, staff and managers. The service was responsive to listening to concerns or ideas made by patients and their relatives to improve services. Staff considered these ideas and used them when they could. Staff had developed pamphlets for children to explain why their parents had been admitted to a psychiatric ward. The pamphlets were presented as stories, were age appropriate and used pictures to get the information across.

- The service had clear guidance in place to report incidents and support staff learning when things had gone wrong.
- Ward staff provided clinical quality audits, human resource management data and data on incidents and complaints. The information was summarised, updated daily and presented in a key performance indicator dashboard. Staff had good access to robust governance systems, which enabled them to monitor and manage the wards effectively and provide information to senior staff in the organisation and in a timely manner.
- All staff had good morale and said they felt well supported and engaged with a visible and strong leadership team, which included both clinicians and managers. Staff were motivated to ensure they achieved organisational objectives. Without exception, staff spoke highly about the senior management team.

However:

- The senior management team had only been in post for four months and staff had concerns about the stability of this team, given the hospital had 11 managers over a ten-year period.

Summary of findings

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Good 

Cygnets Hospital Woking

Services we looked at

Forensic inpatient/secure wards

Summary of this inspection

Background to Cygnet Hospital Woking

Cygnet Hospital Woking is registered to provide the following regulated activities; treatment of disease disorder or injury; assessment or medical treatment for persons detained under the Mental Health Act 1983; and diagnostic and screening procedures.

Cygnet Hospital Woking had an interim registered manager in place.

Cygnet Hospital Woking provides low secure services for men and women.

At the time of inspection, there were two wards in use.

Greenacres 17 beds for men, low secure admission, assessment and treatment

Oaktree 11 beds for women, low secure admission, assessment and treatment

We have inspected Cygnet Hospital Woking 12 times since registration with the Care Quality Commission in November 2010. The last inspection took place in June 2017 and the service was rated as inadequate overall. At that inspection, we identified several breaches of regulations relating to the child and adolescent mental health (CAMHS) ward that closed in November 2017. Cygnet Woking is no longer in special measures as the provider closed the CAMHS service. The breaches included:

- That the provider did not ensure that staff responded appropriately to calls for assistance on the CAMHS ward in good time to safely manage people's changing needs.
- The provider did not do all that is reasonably practicable to mitigate the risk of harm to young people of assault by other patients in the CAMHS ward.
- The provider did not do all that is reasonably practicable to ensure that patients' ongoing physical health conditions including weight gain were managed safely on the CAMHS ward.
- The provider did not ensure that staff on the CAMHS ward had the necessary competencies, skills and experience to apply the engagement and enhanced observation policy, thereby placing young people at increased risk of harm.

- The provider did not ensure that staff on the CAMHS ward were compliant with the proper and safe management of medicines.
- Safeguarding systems and processes were not operated effectively within the hospital to prevent abuse of young people occurring or to enable the immediate investigation of any allegation or evidence of abuse.
- The provider did not establish and operate effectively an accessible system within the CAMHS service for identifying, receiving, recording, handling and responding to complaints by service users and other persons.
- The provider had not established effective systems or processes to introduce measures to reduce or remove risks associated with self-harm whilst under enhanced observation on the CAMHS ward.
- The provider did not have a system in place to ensure that contemporaneous assessment of risk factors were recorded in the risk assessment document.
- The provider did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons on the CAMHS ward to ensure patients were safely observed and protected from harm.
- The provider did not ensure that all staff received appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to effectively carry out the duties they were employed to perform.
- The registered person did not notify the Care Quality Commission without delay of incidents of abuse or allegations of abuse in relation to the safeguarding of young people on seven occasions in the CAMHS service.

In June 2017, the two forensic, low secure wards received a rating of good overall, a rating of good for each key question and had no regulation breaches. The breaches relating to the CAMHS service were not followed up by the Care Quality Commission as the provider closed the ward.

Summary of this inspection

Our inspection team

The team that inspected the forensic inpatient/secure wards comprised of five people: two inspectors and one assistant inspector from the Care Quality Commission,

one mental health nurse and one expert by experience (someone who has developed expertise in health services by using them or through contact with those using them – for example as a carer).

Why we carried out this inspection

We inspected these services as part of our on going comprehensive mental health inspection programme and to ensure improvements had been made following our inspection in June 2017.

How we carried out this inspection

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

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

This was an announced inspection.

Before the inspection visit, we reviewed information that we held about the location and spoke with commissioners of the services.

During the inspection visit, the inspection teams:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with eight patients who were using the service and collected feedback from four patients using comment cards;

- spoke with five family members of patients;
- spoke with the interim hospital manager, the medical director, the clinical services manager and both ward managers;
- spoke with 20 other staff members including doctors, nurses, support workers, occupational therapists, psychologists, a pharmacist and a social worker;
- spoke with an independent advocate;
- held three staff focus groups attended by 18 staff including nurses, clinical support workers, doctors, occupational therapists, psychologists and support service staff;
- attended and observed two hand-over meetings and two multidisciplinary meetings;
- looked at 11 care and treatment records of patients;
- carried out a specific check of the medication management on the wards and reviewed 16 medicine charts;
- looked at six staff recruitment files;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with eight patients, five of their relatives and received four comment cards. Comments were positive and complimentary about care provided on both of the wards. Every patient and relative spoken to commented

on the effectiveness of the treatment and therapy programmes. Patients said staff were caring and kind towards them. All of the patients we spoke with felt actively involved in choosing and making decisions about

Summary of this inspection

their care and treatment. Patients told us that the staff had the patients' best interests in mind and that they tried to equip patients well for effective and safe life in the community.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as good because:

- The ward environments were safe and clean.
- There were enough suitably qualified and trained staff to provide care to a safe standard.
- Arrangements were in place for staff to provide effective support for patients.
- Senior managers were flexible and responded well if the needs of patients' increased and additional staff were required.
- All staff had received training in safeguarding adults and children at risk.
- Patients' risk assessments and plans were recovery focused and person-centred.
- Blanket restrictions were always revisited and reviewed. Staff and patients audited restrictions, together, every month.
- The service had clear mechanisms in place to report incidents and to support learning when things went wrong.

Good



Are services effective?

We rated effective as good because:

- The assessment of patients' needs and the planning of their care was thorough, individualised and had a focus on recovery.
- Patients had good access to physical healthcare, including access to specialists when needed.
- There was evidence of best practice in, and all staff had a good understanding of, the Mental Health Act 1983 (MHA), the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and the associated Codes of Practice.
- Patients had access to a variety of psychological therapies as described as best practice in The National Institute for Health and Care Excellence guidance. This therapy was delivered either on a one-to-one basis or in a group setting. Skilled staff delivered care and treatment. Throughout the wards, the multidisciplinary team was consistently and pro-actively involved in patient care.

Good



Are services caring?

We rated caring as good because:

- Staff were kind, caring and motivated and we saw good, professional and respectful interactions between staff and patients during our inspection.

Good



Summary of this inspection

- There was evidence of initiatives implemented to involve patients in their care and treatment.
- Patients told us that the staff at the hospital consistently asked them for feedback about the service and how improvements could be made. Patients from each ward were appointed ward representatives and met regularly with other patients, at the 'people's council', to receive feedback, which in turn they discussed with staff and managers.
- A series of mental health educational seminars were held for patients' family, friends and carers.

Are services responsive?

We rated responsive as good because:

- The management of the beds on both wards was robust and effective.
- The service model optimised patients' recovery, comfort and dignity.
- The needs of patients were considered at all times by staff.
- There was a varied, strong and recovery-orientated programme of therapeutic activities available every week.
- Self-help leaflets were widely advertised on managing depression, anxiety, voices, self-harm and substance misuse and trauma.
- Staff had developed pamphlets for children to explain why their parents had been admitted to a psychiatric ward. The pamphlets were presented as stories, were age appropriate and used pictures to get the information across.
- The service was particularly responsive to listening to concerns or ideas made by patients and their relatives to improve services. When staff were able to, these ideas were taken on board and implemented. For example, catering staff had met with patients to discuss their dietary requirements and food preferences.

Good



Are services well-led?

We rated well-led as good because:

- All staff had good morale and said they felt well supported and engaged with a visible and strong leadership team, which included both clinicians and managers. Staff were motivated to ensure they achieved organisational objectives. Without exception, staff spoke highly about the senior management team.

Good



Summary of this inspection

- Governance structures were clear, well documented, adhered to and reported accurately. These are controls put in place so that managers can assure themselves that the service delivered is effective and delivered to a good standard.
- Managers and their staff were fully committed to making positive changes. Changes had been made to ensure improvements to quality were made. For example, patients took part in auditing any rules on the ward, implementing a least restrictive practice strategy and action plan.
- However:
- The senior management team had only been in post for four months and staff had concerns about the stability of this team, given the hospital had 11 managers over a ten-year period.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Of all staff 81% had received updated training on the Mental Health Act.
- Care record files were in order and easy to navigate. The Mental Health Act documentation was present and easily available on all the files we reviewed.
- There was active involvement of the independent mental health advocacy (IMHA) service.
- Copies of up-to-date section 17 leave forms were kept in a file accessible in the nurses' office. The forms were comprehensive, clearly detailing the levels, nature and conditions of leave.
- Assessments of patients' capacity to consent to treatment were recorded at the point that medicine certificates were issued and reviewed. The certificates were reviewed in line with the provider's policy.

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had undertaken Mental Capacity Act training. There was a Mental Capacity Act policy in place and staff told us about the principles and how they applied to their patients.
- Where a patient's health was deteriorating, the psychiatrist undertook frequent mental capacity assessments to ensure the person had capacity to consent or refuse treatments.
- No patients on the ward were being treated under the Mental Capacity Act. There were no current Deprivation of Liberty Safeguard applications and this was appropriate. (Deprivation of Liberty safeguards aim to make sure that people in hospitals who lack capacity to consent to admission and treatment are looked after in a way that does not inappropriately restrict their freedom).






Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Good 

Safe and clean environment

- The layout enabled staff to observe most parts of the low secure wards. Staff managed any difficulty in observation through individual patient risk assessments, having a presence in areas of the wards where they could view the bedroom areas and regular checks of patients. Mirrors were used to help staff observe areas where full sight was not possible. Staff followed the provider’s observation policy. There were sufficient staff available to increase the observation of patients at a high risk of self-harming, for example. There was closed circuit television (CCTV) in the communal areas of both wards, which could be viewed from the staff office. We were told the CCTV was reviewed after an incident to support the staff to ensure that lessons were learned from the incident.
- There were ligature risk assessments for both wards, which had been completed within the preceding year. The provider had an ongoing maintenance and capital-build programme in order to mitigate ligature risks on the wards. The programme included the fitting of anti-ligature fixtures and fittings. Staff had received training on managing ligature risks and staff knew where the high-risk ligature anchor points and ligatures were and how these risks were reduced and managed. Ligature risk maps were available to provide a visual aid to staff to direct them to where the high-risk areas were. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Induction packs for new staff included

clear guidance on how ligature risks were managed and how to report new risks. Staff had identified high-risk areas such as the bathrooms, lounges and dining rooms and ensured they regularly monitored these areas. Ligature cutters were accessible in the ward nursing offices.

- Both low secure wards complied with the Department of Health guidance on same sex accommodation as men and women were accommodated on separate wards.
- Each ward had a clean and tidy clinic room. Staff kept appropriate records of the rooms, for example, these showed regular checks took place to monitor the fridge temperatures for the safe storage of medicines. Emergency equipment and medicines were stored on the wards in the clinic rooms. An automated external defibrillator and anaphylaxis pack was in place on each ward to use in an emergency and staff knew how to use the equipment. The wards had access to an electrocardiogram machine. An electrocardiogram is a test, which measures the electrical activity of the heart to show whether it is working normally. Equipment such as weighing scales and blood pressure machines were regularly calibrated by an external company and the equipment was checked on a regular basis. Ward managers and the senior management team carried out and kept records of regular walk arounds to ensure that equipment and furniture were clean and well maintained.
- In June 2017, clinical staff and senior managers had undertaken a comprehensive review of the environments and the usage of the seclusion rooms on both wards. Because of this review, seclusion rooms had been decommissioned and were no longer used for this purpose. Each ward had extra care areas which were used for patients who needed to be nursed away from

Forensic inpatient/secure wards

the wards. Seclusion is the supervised confinement of a patient to contain severely disturbed behaviour, which is likely to cause harm to others. The extra care areas were used for de-escalation and provided a quiet, low stimulus space for patients experiencing high levels of arousal who did not require a period of seclusion. The areas were used appropriately and in keeping with the Mental Health Act Code of Practice guidance. Staff felt confident that their training in the prevention and management of violence and aggression meant they intervened and supported patients before there was a need for physical restraint and therefore seclusion was no longer necessary.

- Both wards were clean, well maintained and had good furnishings and fittings. Cleaning schedules were available to guide staff. In addition, there were audits of infection control and prevention and staff hand hygiene to ensure that patients and staff were protected against the risk of infection.
- Alarms were available throughout the wards in bedrooms, bathrooms and toilets. Staff carried individual alarms. Pagers were carried by staff and indicated the location of any alarm activated. Staff and patients said that alarms were responded to quickly.

Safe staffing

- The number of nurses and healthcare assistants identified in the staffing levels set by the provider matched the number on all of the shifts across both wards. The staffing establishment on each of the wards were individually set to meet patients' needs. The agreed staffing establishment enabled the ward staff to provide the day-to-day care of patients safely. Ward managers were additional and not counted in the numbers.
- The nurse in charge of each ward entered the planned staffing numbers for the shift and the actual numbers on duty for that shift. These were then reviewed every morning with the senior management team and members of the multidisciplinary teams in their morning 'flash' meeting.
- The total number of substantive staff across the two wards was 53 and because the CAMHS wards had closed in 2017, there were no staff vacancies across the service. The provider was due to open two new wards for adults

of working age in spring 2018 and therefore there had been a recent programme of recruitment. When bank and agency staff were needed managers used temporary staff who were familiar with the wards.

- Staff said senior managers were flexible and responded well if the needs of the patients increased and additional staff were required. We saw examples during our visit of extra staffing being made available. For example, to provide one-to-one observation of patients in response to a change in their individual needs.
- Qualified nurses were present in communal areas of the wards at all times. There were sufficient qualified and trained staff to safely carry out physical interventions. Eighty nine% of all staff were trained in basic life support and 82% in intermediate life support.
- Staff were available to offer regular one-to-one support to their patients. Patients said they were offered and received a one-to-one session with a member of staff most days. Information from the patients' daily records showed that this was the case. Patients and staff said planned leave and activities were rarely cancelled due to staff shortages. Dedicated staff had the role of drivers to take patients and their escorts out and this kept any cancelled leave to an absolute minimum.
- There was adequate medical cover over a 24-hour period, seven days a week across the two wards. Outside of office hours and at weekends, on-call doctors were available to respond to and attend the hospital in an emergency. Consultant psychiatrists provided cover during the regular consultant's leave or absence.
- The compliance for mandatory training courses at February 2018 was 92%, above the provider's target of 90%.

Assessing and managing risk to patients and staff

- Risk assessments were completed for all patients on admission to the hospital and followed the format in the electronic care record system. Staff used nationally recognised risk assessments and tools such as the 'historical, clinical and risk management scales' and the 'structured assessment of protective factors for violence risk'. This is a set of comprehensive guidelines for assessing risk of violence. Each patient had a completed document within their care record known as the 'Salford' tool for assessment of risk. This was a clinically recognised tool that identified the risk triggers for each patient and enabled the staff to support the patient and identify what actions to take to reduce their level of risk.

Forensic inpatient/secure wards

- Risk assessments were updated following any incidents. The percentage of clinical staff that had received risk assessment and management training was 98%.
- Staff said, where they identified particular risks, they safely managed these by putting in place relevant measures. For example, the level and frequency of observations of patients by staff were increased in response to increased risks. Risk assessments were detailed, complete and comprehensive.
- Staff discussed and shared risks in the daily handover meetings and in a written handover to all staff. The senior management team and representatives from the multidisciplinary team discussed risks on each ward at the daily 'flash' meeting. Other potential risk issues were looked at in this meeting including, safe staffing, availability of escorts, any patient assessments due, enhanced observations, physical health deterioration, any rapid tranquilisation incidents, any safeguarding concerns, any use of restraint or seclusion, any long term segregation and any admissions or discharges.
- In addition each ward carried out a daily 'zoning' meeting where risk issues for each patient were discussed and rated high, red risk, medium, amber risk or low, green risk. The meetings involved all available staff to discuss specific patients' risks and any potential harm that may affect patients.
- The provider had a 'reducing restrictive practices' strategy and action plan in place. Any restrictions on the wards had been thought through with staff and patients before implementation or had a clear rationale. For example, patients admitted to the wards underwent searches to ensure no contraband was brought into the ward. This was to ensure a safe environment for patients and staff and this had been put in place following incidents of contraband being brought onto the wards. Contraband is an item, which is banned from the ward such as weapons, drugs or alcohol. A list was displayed showing these banned items. Staff said us that patient searches were done in a supportive and dignified way, ensuring it was conducted in a private area of the ward and by the appropriate gender of staff. Staff said blanket restrictions were always revisited and reviewed. Staff and patients audited restrictions every month. They looked at the rule or restriction, the reason for it, the negative impact it had on patients and came up with a suggested solution to reduce or eliminate the rule. We were told about many examples of blanket restrictions which had been revised which included, patients having their own mobile phones on the ward and some patients, if assessed as safe to do so, had their own phone chargers. Patients had their own keys to their bedrooms, which, they could access at any time and both kitchens on the wards were kept open at all times.
- From May 2017 to the end of November 2017, there were two incidents of seclusion on both wards. Since the seclusion rooms had been de-commissioned there were no incidents.
- All staff received training which included the management of actual and potential aggression. Staff practiced relational security and promoted de-escalation techniques to avoid restraints where possible. Relational security is the way staff understand their patients and use their positive relationships with patients to defuse, prevent and learn from conflict. The hospital was a member of the 'restraint reduction network' and had introduced 'reducing restrictive practices champions' on each ward.
- From May 2017 until the end of November 2017, there were 82 incidents of restraint, 17 on Greenacre ward with six different patients and 65 restraint incidents on Oaktree involving five patients. Eight of these incidents involved prone restraint. Prone restraint is a face towards the floor position which should be avoided as it can compress a person's ribs and limits an individual's ability to expand their chest and breathe. Additionally, a person who is agitated and struggling needs extra oxygen and they are unlikely to get sufficient oxygen in the prone position. Staff said patients would be moved out of the prone position as soon as it was safe to do so and appropriate physical healthcare monitoring took place when rapid tranquilisation was administered. Out of the prone restraint episodes, only one resulted in the administration of rapid tranquilisation.
- There was one ongoing use of long-term segregation (LTS) over the 12-month reporting period. We looked at this patient's care records in detail. There was a clear rationale for the commencement of LTS, with evidence that it was necessary as a 'last resort' of managing disturbed behaviour. Detailed care plans were in place and focused on what needed to be achieved to end LTS, by the patient and by staff. Considerations had been made on how to nurse the patient in the least restrictive manner possible in the circumstances, including access

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to fresh air, occupational therapy and psychology input, activities and opportunities for human contact. The provider was trying to transfer this patient to a more secure setting.

- All of the staff we spoke to knew how to raise a safeguarding issue or concern. Staff said they completed an electronic incident form and informed the nurse in charge or the ward manager. All staff were aware of who the provider's safeguarding lead was and how to contact them. The safeguarding team contact details and flow charts of the safeguarding procedure were placed in the wards both in the nurses' office and on the patients' notice boards. Ninety five% of staff had up to date safeguarding training.
- Staff told us how they kept patients safe from harassment and discrimination by observing behaviours on the wards and between patients and visitors. The provider had strong working relationships with the local safeguarding team and monthly meetings took place.
- There were appropriate arrangements across the wards for the management of medicines. All nursing staff had a medicine competency assessment carried out before administering medicines. Staff gave patients information about their medicines. When we checked, there were no errors or omissions in the recording of medicines dispensed. If patients had allergies, these were listed on the front of the prescription chart. We looked at the medicines ordering process and saw the process for giving patients their regular medicines. All medicines checked were available and in date. There were good processes and procedures in place on the wards in relation to medicines reconciliation. This is where the ward staff contact GP's on admission to confirm what medicines and dosages the patient was taking so that these medicines could continue while the patient was on the ward. Staff discussed medicines in multidisciplinary care reviews. A pharmacist visited the wards and carried out routine audits to ensure that staff were managing medicines safely. Patients at risk of side effects from taking high-dose antipsychotic medicines were monitored. Medicine to be given when required was prescribed for patients appropriately. Staff regularly reviewed and discontinued these if no longer needed. Medicines to be given to patients detained under the Mental Health Act were documented accurately. Forms

were always signed by the consultant overseeing the patient's treatment, and by the patient, if they had capacity to do so, or by a second opinion appointed doctor.

- The wards had access to a family room where patients met family members, children and friends if it was risk assessed as safe to do so. All patients due for visits were risk assessed on the day to assess if the visit could take place safely. The family room was located off the wards.

Track record on safety

- The provider reported 11 serious incidents from July to the end of November 2017. These included five incidents of disruptive and aggressive behaviour by patients, two incidents of information governance breaches, one incident of alleged abuse by a third party, one incident of alleged abuse by staff, one medication error and one death of a patient, post discharge.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents on the providers' electronic recording system. All staff had received training on incident reporting. Incidents and lessons learnt from incidents was shared at the wards' daily handover meetings, regular team meetings and the daily 'flash' meeting. Incidents were presented in a monthly summary report, which detailed when incidents took place and what had occurred. Staff gave us examples of incidents reported and lessons learnt relating to safeguarding patients, the use of rapid tranquilisation, self-harm, assault and verbal abuse. Staff were able to discuss recent incidents and concerns from across the hospital and action taken to avoid re-occurrences. The provider implemented a debriefing policy following incidents and staff confirmed these took place. Staff also debriefed patients following incidents.
- Staff understood the Duty of Candour and told us they were open and transparent with patients and their families if something went wrong. Ninety one% of staff had received training on the Duty of Candour. Managers said they had received training, paying particular attention to the quality of the incident investigations,

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how they engaged families and carers in reviews when things go wrong. It also covered how they identify lessons, share learning and demonstrate change in practice.

- The psychology team carried out reflective practice sessions on both wards where the multidisciplinary team discussed and formulated responses to support in the management of some of the more challenging patients.

Are forensic inpatient/secure wards effective? (for example, treatment is effective)

Good 

Assessment of needs and planning of care

- We reviewed 11 care records and all patients had detailed and timely assessments of their current mental state, previous history and physical healthcare needs. The care plans were recovery focused, holistic and demonstrated good practice. A care planning good practice tool called 'my shared pathway' was used and assisted staff and patients to plan care, set goals and monitor progress. Patients told us that they were included in the planning of their care and, where they had chosen to, had a copy of their care plan. All patients, where they had agreed to, had a physical health screening. All patients had a 72-hour care plan completed following admission. A physical examination was carried out for all patients on admission and included a routine blood test and electrocardiogram. Care plans were updated weekly in clinical review meetings.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medicines, in relation to options available for patients' care, their treatment and wellbeing, and in assuring the highest standards of physical health care delivery. Staff also used NICE guidance in the delivery of the therapeutic programme that included nationally recognised treatments for patients. Patients had access to a range of psychological therapies such as cognitive behaviour

therapy, mindfulness, occupational therapy, dialectical behavioural therapy, acceptance and commitment therapy, eye movement desensitisation and reprocessing therapy, motivational interviewing, humanistic and psychodynamic interventions and these were delivered via one to one sessions and in groups. Patients told us therapies had helped them to gain insight and to decrease their anxiety and had equipped them to address their issues and journey to recovery. Psychologists helped staff set up behaviour support plans for patients who had challenging behaviour.

- Staff described how they developed physical health care plans and effectively managed physical health care needs. The provider had a full time practice nurse who specialised in physical healthcare. She provided a weekly health promotion group on each ward covering topics such as, smoking cessation, sexual health and healthy eating. A GP visited each ward weekly. Staff supported the integration of mental and physical health and staff developed comprehensive care plans that covered a range of physical health conditions such as diabetes, cardiac conditions, cancer, addictions and breathing problems. Staff carried out physical health observations for all patients using the national early warning score.
- Occupational therapists provided specialist psychological and social based educational groups. A wide range of additional activities were also available including a range of arts and crafts, music, cookery and trips to the local community. All patients were assessed using the nationally recognised 'model of human occupation screening tool'. Interventions offered included basic activities of daily living, behavioural interventions, community living skills, educational, developmental and health promotion knowledge and skills.
- Staff used the recognised rating scales known as the 'health of the nation outcome scale' to assess and record outcomes. These covered 12 health and social domains and enabled clinicians to build up a picture over time of their patients' responses to interventions.
- Staff engaged in clinical and management audits and a medical advisory committee, chaired by the medical director oversaw the clinical audit programme. These audits included ensuring good physical healthcare for patients, ensuring accurate Mental Health Act processes, risk assessing ligature risks on the wards, reviewing any blanket restrictions, resuscitation simulation drills,

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ensuring patients had positive behaviour support plans and medicine management. Staff audited risk assessments and care plans to ensure quality and completion.

- Staff representatives from each ward, senior clinicians and managers attended monthly meetings to review clinical effectiveness and looked at, for example, models of care, quality of care records, physical health promotion, consent, audit and research.

Skilled staff to deliver care

- The staff on both wards came from various professional backgrounds, including medical, nursing, social work, occupational therapy and psychology. Staff were experienced and qualified to undertake their roles to a high standard.
- All staff received a thorough three-week induction into the service, which used the 15 standards set out in the Care Certificate programme as a framework. Agency and bank staff also received a detailed induction.
- Staff received appropriate training, supervision and professional development. The provider had reached 98% compliance with supervision. Staff were encouraged to attend additional training courses. For example, ward managers were encouraged to undertake leadership courses and staff on the wards had received training in mindfulness. A bespoke training programme for senior support workers, called 'basics to brilliance' had been delivered and staff spoke very highly about the training. Support workers were encouraged to co-ordinate shifts, attend multidisciplinary meetings and be actively involved in patients' care planning. A medical academic programme had been set up and a forum for ongoing learning to support staff members' professional development took place every month. This work was overseen by the integrated governance committee.
- The staff appraisal compliance rate was 94% and medical revalidation was at 100%.
- Preceptorship training was offered to newly qualified nurses. This helped ensure that they had the skills needed to complete their role and that they were well supported.

Multidisciplinary and inter-agency team work

- Well-staffed multidisciplinary teams worked across the two wards. Regular team meetings took place. We observed care reviews and staff handover sessions and found all of them to be effective.
- Staff worked with other agencies. There were links with the local authority, local primary care teams and housing organisations being particularly positive examples.

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

- We looked at care records of patients who were detained under the Mental Health Act. The Mental Health Act documentation was present and available in the records. Each ward maintained an updated patient board that detailed when rights should be repeated for each patient. This information was audited every week.
- There was active involvement of the independent mental health advocacy service, and information about the service was displayed on information boards in communal areas.
- Patients were encouraged to contact the Care Quality Commission if they chose to about issues relating to the Mental Health Act. This was contained in the welcome pack given to all new patients.
- Each ward had access to a Mental Health Act (MHA) administrator who monitored requirements and compliance with the Act and Code of Practice. A spreadsheet was updated to provide information on patients' current MHA section status, date consent was given, date rights last given, capacity form completed and any tribunal applied for or held.
- Copies of up-to-date section 17 leave forms were kept electronically and in files accessible in the nurses' offices. The forms were comprehensive, clearly detailing the levels, nature and conditions of leave. These were regularly reviewed and updated. Staff recorded who had been given copies of the section 17 leave forms.
- Assessments of patients' capacity to consent to treatment were available. We found that medicine certificates were reviewed in line with the provider's policy. These certificates show that patients detained under the Mental Health Act had the proper consent to treatment in place.
- As of February 2018, 81% of staff had received training in the Mental Health Act and staff were able to confidently discuss all aspects of the Act.

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Good practice in applying the Mental Capacity Act

- The provider had a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) policy in place. Staff had a good understanding of the MCA and 97% of staff had updated training. Staff knew where to get advice regarding MCA, including DoLS, within the hospital. Where required, Deprivation of Liberty Safeguards applications were made however, none had been made in the preceding six months.
- The provider had arrangements in place to monitor adherence to the MCA.
- For patients who might have impaired capacity, capacity to consent was assessed and recorded appropriately. This was done on a decision-specific basis with regards to significant decisions and patients were given assistance to make specific decisions for themselves before they were assumed to lack the mental capacity to make it. Patients were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the patients' wishes, feelings, culture and history.
- Specialist independent mental capacity advocacy was available to all patients if needed.

Are forensic inpatient/secure wards caring?

Good 

Kindness, dignity, respect and support

- Patients we spoke with on both of the wards were complimentary about the staff providing their care. Patients told us they got the help they needed. Patients told us they had been treated with respect and dignity and staff were polite, friendly, and willing to help. Patients told us staff were pleasant and were interested in their wellbeing.
- Patients told us staff were consistently respectful towards them. Patients said the staff tried to meet their needs, that they worked hard and had patients' best interests and welfare as their priority. During our inspection, we saw nothing other than positive

interactions between staff and patients. Staff spoke to patients in a friendly, professional and respectful manner and responded promptly to any requests made for assistance or time.

- Staff assisted patients to access other services to help meet their needs. For example, staff promptly referred patients to a variety of primary care healthcare professionals.
- Staff showed patience and gave encouragement when supporting patients. When patients became distressed and agitated, staff intervened gently and in kind and pleasant ways. These interventions calmed patients considerably.
- All staff we spoke with had an in-depth knowledge about their patients including their likes, dislikes and preferences. Staff understood the individual needs of their patients, including their personal, cultural, social and religious needs. All staff had received training in equality, diversity and human rights.
- Staff said they could raise any concerns about disrespectful, discriminatory or inappropriate attitudes or behaviour towards patients without fear of the consequences.
- Staff ensured information about patients was kept confidential.

The involvement of people in the care they receive

- Where patients had a planned admission to the wards they had already received information about the hospital which included information about health needs, the multidisciplinary team providing care, treatment and therapy options, medicine and physical health needs, daily life on the ward, recreation and leisure needs. The booklet orientated patients well to the service and patients we spoke to about the booklet had received a copy and commented on it positively.
- There was evidence of patient involvement in the care records we looked at, particularly captured in the 'my shared pathway' documentation on the electronic care notes. This approach was person centred, individualised and recovery orientated. We also saw that all patients reviewed their care plan once every month with the multidisciplinary care team and in regular meetings with a member of the ward nursing team.
- During our inspection, we joined a number of multidisciplinary care review meetings on the wards

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where the views and wishes of the patients were discussed with them. Options for treatment and therapy were given to the patients to consider at all of the meetings.

- Information was advertised on all of the wards about local advocacy services available.
- Patients had a number of ways of being actively involved in giving feedback about the service and also getting involved in shaping services. For example, each ward held a morning planning meeting and a weekly community meeting which was attended by the patients and representatives from the clinical team and managers. Each ward had a patient representative who attended ward and hospital-wide meetings to take forward any issues they wanted addressed. A well-established patients' council, called the 'people's council' met regularly with all patient representatives from each ward. A patients' open forum meeting was held four times a year. The people's council had brought about changes, such as the introduction of mobile phones for patients to use on the wards and acquiring a variety of new fixtures and fittings. A 'you said and we did' initiative had been started and staff and patients told us about many examples of change having been made as a result. For example, patients now had internet access, DVD players were available on the wards and newspapers and magazines were purchased each week for patients. Patients were trained to assist in staff interviews. Patients helped to design and deliver training material for staff and patients. Patients worked with staff on events to raise money for charities and visited colleges and universities to talk about mental health and to reduce stigma.
- The provider had appointed an expert by experience lead who regularly visited the hospital to assist the ward representatives in their role.
- Patients were asked about their experiences of using the service regularly and this process was led by a local advocate. Patients told us changes had been made as a result of their feedback, such as patient involvement in menu planning and choosing new furniture on the wards
- Patients said that, where they had wanted to, their families were included in their care planning. Information leaflets and regular newsletters were made available to relatives and friends and regular information and educational sessions were available at the hospital.

Are forensic inpatient/secure wards responsive to people's needs? (for example, to feedback?)

Good 

Access and discharge

- The average bed occupancy for the service in a six-month period prior to inspection was 80%. The service was a regional service and admitted patients from the South of England, although there were some patients from the local area.
- Beds were kept available for patients returning from weekend or transitional leave and patients were moved on to other services based on their assessed clinical needs.
- Patients were discharged to the community or transferred to an alternative hospital placement by arrangement during the working week and at an appropriate time of day.
- There had been no delayed discharges in the six-month period prior to our inspection.

The facilities promote recovery, comfort, dignity and confidentiality

- Both wards had a full range of rooms and equipment available, including spaces for therapeutic activities and treatment, in addition to a central occupational therapy centre, which was a spacious, well equipped area with a gym, kitchen and training rooms.
- Patients had their own bedroom. Patients were able to store their possessions securely in their bedrooms. All patients had access to their bedrooms and communal areas of the ward at any time. Many patients had wider access across the hospital site and access in and out of their own ward areas.
- Patients on the wards had access to snacks and hot and cold beverages at all times of the day and night.
- Patients spoke highly about the quality and range of food provided. The head chef and catering staff attended patient community meetings to seek the views of patients. A dietitian was involved with menu planning. All new patients had a dietary sheet filled out with any special requirements or allergies. There were many meal choices and patients were fully involved in

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discussions about what should go on the menu. The catering department had produced an information brochure with advice about healthy eating, healthy snack choices and how to choose a healthier takeaway. The kitchen staff had recently received a five star rating from the local authority.

- Quiet rooms were available where patients could meet visitors.
- Both wards had access to private pay phone facilities, in addition to patients having their own mobile phones.
- All wards had direct access to extensive garden areas and patients helped staff with gardening. All patients were able to enjoy the outside facilities, albeit some with staff supervision.
- Daily and weekly activities were advertised widely and available on both wards. The activities were varied, recovery focused and aimed to motivate patients. Staff provided activities in the evenings and across weekend periods. Examples of activities on the wards included healthy lifestyle sessions, exercise, gym, cycling, yoga, walking, cooking, arts and craft.

Meeting the needs of all people who use the service

- Both wards had full disability access.
- Patients had access to a multi-faith room and a variety of spiritual support. Patients spoke positively about their regular contact with the chaplaincy service. The chaplain visited the hospital on a weekly basis or more frequently if required. Patients gave examples of their cultural needs being met such as access to culturally appropriate food and visits to local faith buildings or visits from faith leaders. Contact details for representatives from different faiths were available on the wards.
- Information was available in other languages if needed. Self-help leaflets were widely advertised on managing depression, anxiety, voices, self-harm and substance misuse and trauma. Interpreters were used if necessary and the staff were aware of the process for arranging this service.
- Staff had developed pamphlets for children to explain why their parents had been admitted to a psychiatric ward. The pamphlets were presented as stories, were age appropriate and used pictures to get the information across.

Listening to and learning from concerns and complaints

- The service received 25 complaints for the year from December 2016. Of these, three complaints were still under investigation, three were fully upheld and seven were partially upheld. The top three themes which emerged after analysis were perceived poor communication towards patients by staff, perceived inappropriate behaviour between patients and patients' property going missing or getting damaged. In response to these themes managers introduced customer care training to all staff during their induction and mandatory refresher training. A 'charter of mutual expectations' was co-produced by staff and patients. A new system of inventory checking patients' property and storage facilities was introduced.
- There was information on how to complain displayed on notice boards and in the patients' welcome packs. The welcome pack explained that detained patients had the right to raise complaints about the Mental Health Act directly with the Care Quality Commission. It also explained how to make complaints and the support available from the advocacy service. Patients said they would complain either directly to staff, or at the daily morning meeting.
- Staff knew the complaints procedure and felt able to manage informal and formal complaints. All staff had received training on handling complaints. Staff met regularly to discuss learning from complaints. This informed a programme of improvements and training, for example, improving communication between staff and carers in relation to care planning.
- Greenacre ward staff received seven compliments and Oaktree staff 17 over the preceding year.

Are forensic inpatient/secure wards well-led?

Good 

Vision and values

- The provider's vision, values and strategies for the service were evident and on display on information boards throughout the two wards. Staff we spoke to understood the vision and strategic objectives of the organisation. Staff said the provider's vision and values was to provide a service, which went the extra mile for patients and was to be responsible, respectful, honest

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and empathetic. Without exception, staff felt very much a part of the service and were able to discuss the philosophy of the wards. Staff had opportunity to contribute to discussions about their service in regular team meetings, the staff relations group and staff forums

- A significant number of members of the hospital senior management team were new in post from November 2017 and included the interim hospital manager, the clinical manager, the medical director and the general manager. This team ensured they had regular contact with all staff and patients. All staff and patients knew who the senior management team were and they felt confident to approach them if they had any concerns. Staff knew who the provider's executive team were and said they visited the wards. Staff were particularly complimentary about the current senior management team. However, staff told us they were concerned about the stability of the team as there had been 11 different hospital managers over a ten-year period.

Good governance

- New governance structures had been introduced in November 2017. Ward staff provided clinical quality audits, human resource management data and data on incidents and complaints. The information was summarised and presented monthly in a report, which all staff could see. These reports were looked at in regular team meetings. Ward managers, senior managers and senior clinicians attended the integrated governance meetings where they looked at patient safety, patient experience and staff management. This meant that the management team were able to receive assurances and apply clear controls to make sure the service ran effectively.
- Staff received their mandatory training, supervision and appraisals. There were sufficient suitably trained staff available on every shift in each ward to deliver safe care to patients. Staff were confident that they learnt from incidents, complaints and patient suggestions and feedback.
- Staff showed us the ward operational risk registers. Staff said they could submit items of risk for inclusion on the risk register. The risk register had inclusions from both the wards and support services, which showed that risks were escalated appropriately from all areas of the service.

Leadership, morale and staff engagement

- Over a four-month period the new senior management team had introduced listening events for staff, hospital manager drop in sessions, staff newsletters, regular Friday updates, a staff survey, 'above and beyond' staff nominations, a colleague-to-colleague recognition scheme and an employee of the month scheme. All staff we spoke with commented on the open, transparent, responsive and visible new senior management team. Staff said communication was superb.
- Ward managers had the skills, knowledge and experience to perform their roles to a high standard. The managers knew their staff and patients well and were able to confidently describe their services.
- Staff said they felt respected, supported and valued in their work. They commented in particular about the support they received from their ward managers. Staff were proud to be working for the provider.
- All staff we spoke with felt confident to raise any concerns and they knew how to do this, including the availability of the whistle-blowing process should they want to use this.
- Managers dealt effectively with poor staff performance appropriately and in a timely manner. During the reporting period, there was one case where staff had been suspended.
- Teams worked well together for the well-being of patients, we saw this happening in clinical care reviews and discharge planning meetings.
- Staff appraisals included discussions on personal and professional development needs and action plans to achieve this development. All staff commented on how their professional development needs had been supported.
- Staff reported that the provider promoted equality and diversity in its day to day work and provided opportunities for career progression. For example, staff described being able to have flexible working practices which enabled them to maintain a good work life balance.

Commitment to quality improvement and innovation

- The hospital was committed to reducing the impact of restrictive practices. Restrictive practice recording files were available on the wards. Restrictions were considered at the level of individual care and staff tried to follow least restrictive principles.

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- The low secure services were part of the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services.
- The hospital supported the service user involvement programme. The hospital management team had recently completed a comprehensive service user feedback report and had introduced a Cygnet People's Council, which captured patients' views and shared these with senior managers.

Outstanding practice and areas for improvement

Outstanding practice

- Staff had developed pamphlets for children to explain why their parents had been admitted to a psychiatric ward. The pamphlets were presented as stories, were age appropriate and used pictures to get the information across.