Cygnet Lodge Brighouse

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 Lodge Brighouse as **good** because:

- The hospital environment was clean and well maintained. Staff undertook environmental risk assessments to mitigate and manage risks. All patients had a comprehensive risk assessment and the hospital used a range of recognised risk assessment tools. The hospital had robust medication management and regular audits to ensure any gaps were being identified. The hospital were learning from incidents and continuously improving the service in order to drive improvement. Compliance with mandatory training was high, with one module achieving below 75%, and the average compliance rate was 90%.
- All patients had up to date care plans which were detailed and reviewed regularly. Patients had access to a full range of multi-disciplinary staff including a psychologist, doctors, registered mental health nurses, occupational therapist, social worker, art therapist, music therapist and health care assistants. Multi-disciplinary meetings were comprehensive and covered all aspects of the patients care including, risk, medication and discharge plans. Staff had a good working knowledge of the Mental Health Act. They had support from a Mental Health Act administrator who was also responsible for ensuring all documentation was correct and up to date.
- Patients and carers told us about how positive their experiences were at the hospital. They highlighted how staff were caring, knowledgeable and hard working. Patients were able to give feedback on the care and treatment they received.
- The hospital had a strong focus on recovery and rehabilitation; they successfully discharged 11 patients in 12 months. It offered its patients a range of facilities that promoted their recovery such as a shared three bedded shared flat-let. Information was made available to patients appropriate to their needs and they were supported to access other services for additional support where this was required.
- Staff morale was positive and staff felt as though they could approach senior staff regarding issues or concerns. They did not feel at risk of victimisation and felt the hospital would support them wherever possible. The ward manager felt she had enough autonomy in to fulfil her role effectively. There were governance systems in place to ensure the running of the organisation was robust. The ward was accredited and committed to quality and improvement.

However,

- Staff were not always confident about discussing the Mental Capacity Act. Their knowledge varied especially around capacity assessments and how best interest decisions are made.
- Although care plans were detailed and comprehensive, the care plans did not always use the patients' own words or contain the views of carers and family members.
- The restraint logs were not always completed in sufficient detail to identify the level of holds used.

Summary of findings

Contents

Good

Location name here

Services we looked at :
Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Cygnet Lodge Brighouse

Cygnet Lodge Brighouse has been registered with the Care Quality Commission since November 2010 to carry out the following regulated activities:

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

Cygnet Lodge Brighouse is a community inpatient rehabilitation service. It is a registered location of Cygnet Health Care Ltd. The service provides care for up to 24 male patients who are highly symptomatic, with multiple or severe co-morbid conditions, forensic histories, significant risk histories and challenging behaviours. At the time of the inspection 17 patients were receiving care and treatment at the hospital.

The Care Quality Commission previously inspected this location in June 2015, and the service was rated as good overall, with a rating of good in each of our five key questions.

Our Mental Health Act Reviewers also visited the service in May 2017. At this visit the reviewer raised concerns about; the use of certificates of treatment and administration errors on admission documentation. We reviewed these concerns during this inspection and found the issues had been resolved.

At the time of our inspection there was no registered manager in place. The previous registered manager for this location left in December 2017. The provider had informed the CQC that the hospital manager was in the process of becoming the new registered manager, they were experienced and qualified for this role. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008, and the associated regulations including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2010.

Our inspection team

The team that inspected the service comprised two CQC inspectors, one expert by experience and three specialist advisors, including two mental health nurses and one occupational therapist. An expert by experience is a person who has experience of using, or caring for someone who uses mental health services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

Summary of this inspection

- visited the service, looked at the quality of the environment and observed how staff were caring for patients
- spoke with nine out of 17 patients
- spoke with three carers
- reviewed five staff personnel files
- looked at six care and treatment records
- attended one multidisciplinary meeting
- spoke with three nurses, three health care support workers, the pharmacist, an occupational therapist and the assistant psychologist
- spoke to the associate specialist and two consultant psychiatrists
- spoke to the ward manager, quality lead, clinical services manager and hospital manager
- reviewed 17 patient medication cards
- reviewed the medication management and equipment within the clinic rooms
- 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 to nine out of 17 patients all of whom were positive about the care and treatment they received at Cygnet Lodge Brighouse. Patients told us staff were kind, caring and hard working. We observed staff interacting with patients and saw that they were both professional and empathic. Staff clearly had developed a positive rapport with patients.

We spoke to three carers all of whom were happy with the care and treatment their family members were receiving at Cygnet Lodge Brighouse. Both patients and carers felt comfortable to raise any concerns or issues with staff without fear of reprisal.

Patients were able to input into the care and service they received. Patients were able to personalise their rooms and hospital environment, and collectively decided on activities they would like to do. Patients were able to discuss any concerns or issues they had and staff presented any changes as a result of the community meetings on a 'you said, we did' wall.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The service had an up to date environmental risk assessment, ligature audit and fire safety assessments. The hospital environment including the clinic rooms were clean, well maintained and had appropriate furniture and equipment.
- The hospital followed best practice in medication management; medication was stored safely, appropriately administered and documented correctly. There were regular audits to identify gaps and improve practice.
- All patients had a risk assessment. Risk assessments were comprehensive and reviewed in a timely manner. Cygnet Lodge Brighouse ward used recognised risk assessment tools to identify and manage risk.
- Staff had an average compliance rate of 90% in their mandatory training.
- The service was learning from incidents and implementing new processes to continuously drive improvement.

However,

- The restraint logs were not always completed in sufficient detail to identify the level of holds used.

Are services effective?

Good

We rated effective as good because:

- Patients has good access to psychology at the hospital and were offered a range of psychological interventions on a one to one basis or as a group, this includedcognitive behavioural therapy, anger management andrelapse prevention.
- The hospital had a range of skilled qualified staff which meant they were able to offer patients holistic support. Staff included an occupational therapist, registered general nurse, music therapist, art therapist, psychologist, a substance misuse worker and a psychologist.
- All patients had detailed and comprehensive care plans which were up to date. The care plans were linked to the 'recovery star' outcomes.
- There was good physical health monitoring within the hospital. All patients had a physical health screening upon admission and it was reviewed regularly during multi-disciplinary meetings. All patients were registered to the local GP.

Summary of this inspection

- Staff had good knowledge around the application of the Mental Health Act. All Mental Health Act documentation was well kept and appropriately managed.

However,

- Staff were not always confident about discussing the Mental Capacity Act. Their knowledge varied especially around capacity assessments and how best interest decisions are made.
- Care plans did not always contain the views of carers and family members and did not use the patients' own words.

Are services caring?

Good

We rated caring as good because:

- Staff on ward demonstrated good care; we observed staff treated patients with kind, compassionate and dignified way.
- It was evident staff had built positive relationships with the patients and they knew their patients well.
- Patients had regular community meetings to discuss concerns, issues and areas of improvement. We saw the hospital responded to requests of patients within a timely manner.
- Patients gave positive feedback on the care and treatment they received, they felt staff went out of their way to support them and that staff were hard working.

Are services responsive?

Good

We rated responsive as good because:

- The hospital had eleven patient discharges in the last 12 months and the average length of stay for patients at Cygnet Lodge Brighouse was 12 months. Average length of stay for a service like this is between one to three years.
- The hospital had three flat-lets which enabled patients to live more independently.
- Patients were able to personalise their bedrooms; they also contributed towards how the hospital environment was decorated.
- There were a range of facilities available for patients at the hospital including a library, a number of comfortable lounges, a pool table, a multi-faith room, an internet room and outdoor space.
- The hospital was able to meet the dietary needs of its patients and offered a choice of dishes during meal times.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- The senior staff and including the hospital manager were aware of the key risks that affected the hospital and understood what plans were in place to manage them.
- Staff morale was good. There was a strong team ethic and staff felt well supported by each other.
- Staff demonstrated to us the values and vision of the provider by their enthusiasm and passion and determination to provide good care.
- The ward manager felt she had enough autonomy in her role to make decisions, but also felt there was appropriate support from the senior managers.
- The provider supported staff development by offering a range of qualifications to upskill themselves, it also including routes into management and leadership.
- The service had embedded the governance pathway and we saw evidence of how managers had moved this down to ward level with the introduction of ward manager data packs.
- The service used a range of resources to encourage feedback about the service which included staff, patient and carer surveys, and had action plans in place to increase uptake.

Detailed findings from this inspection

Mental Health Act responsibilities

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

At the time of our inspection the hospital demonstrated good application of the Mental Health Act. Staff had a good understanding of the Mental Health Act even though their compliance with mandatory training was low at 57%. The service had implemented a new classroom based training for the Mental Health Act in November 2017. The service had prioritised training all qualified staff first.

Staff regularly informed patients of their rights upon admission and thereafter on a monthly basis.

A Mental Health Act administrator was employed by the service and provided oversight and guidance for staff on the application and use of the Mental Health Act. The Mental Health Act administrator had responsibility for ensuring that all paperwork was complete and was responsible for auditing the Mental Health Act documentation.

We reviewed the provider's policy for the 'administration of the Mental Health Act (2016). The Mental health Act manual for staff sat alongside this policy. The policy referenced relevant legislation including the Mental Health Act Code of Practice (2015).

Start here...

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act is legislation that maximises an individual's potential to make informed decision wherever possible. The Act and associated code of practice provide guidance and processes to follow where someone is unable to make capacitated decisions.

At the time of our inspection most staff had received training in the Mental Capacity Act and had a compliance rate of 90%. Staff that we spoke with during our inspection had a variable understanding in the Mental Capacity Act. Staff were not always clear on the process in which capacity is assessed, and how best interests decisions are facilitated. Staff did however have a better understand of the five principles and were more confident in discussing least restrictive practice. Staff understood the appropriate use of restraint and how this impacted on the patients' freedom of movement.

There were no patients subject to the Deprivation of Liberty Safeguards at the time of our inspection.

We reviewed the provider's policy for the Mental Capacity Act (2016). The policy was thorough and explained the principles of the Act and contained relevant guidance including updates from the 2014 supreme court judgement in relation to Deprivation of Liberty Safeguards.

Overview of ratings

Our ratings for this location are:

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

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

Cygnet Lodge Brighouse was a 24 bed male long stay rehabilitation ward. The hospital comprised 21 bedrooms, all with en-suite facilities, and a three bedroom flat-let for patients with more independence. The flat-let comprised three patient bedrooms with fitted ensuites and a shared living room and kitchen. The rooms were located on the first and second floor of the building, and all activity and patient areas were on the ground floor. The main entry into the hospital was on the first floor. The hospital had two bedrooms which had disability access.

We found the hospital environment clean and well kept. Fixtures and furnishings were in good condition and optimised patient comfort.

The hospital had an environmental risk assessment and ligature audit which had been completed within the last 12 months in line with the provider policy. Staff had appropriately identified the ligatures on the audit and how they could be mitigated. The service were adopting a new method to ensure staff could easily identify where ligatures were located within the service. All ligature risks were to be pinpointed on a floor map of the hospital and displayed in the staff office. The hospital had annual fire assessments from an external company within the last 12 months and had the appropriate documentation to support this.

The clinic room was clean and well maintained. Medication resuscitation equipment and emergency drugs were easily accessible and stored in the clinic room. Emergency equipment was clean and readily available; this included a defibrillator and an oxygen tank. Staff checked and the emergency bag on a daily basis. We found that the clinic room was clean with adequate space available for the preparation of medication doses. Equipment for the monitoring of physical health was available and included a blood pressure monitoring machine and weighing scales. Equipment had been calibrated accordingly.

The hospital adhered to infection control principles. There was appropriate signage for staff to follow to maintain safety and cleanliness, for example the kitchen had the correct signage for cooking, cleaning and storage of food. Control of Substance Hazardous to Health equipment was stored safely. There were appropriate hand washing facilities and alcohol gel dispensers located at various points within the hospital with signage encouraging the use of them. The hospital employed a full time housekeeper and a maintenance worker; any building issues were responded to in a timely manner.

All patient bedrooms, corridors and activity rooms had nurse alarm call buttons. Location boxes were located though out the hospital which help staff identify where the alarm had been activated. Staff also carried alarms on their person in the event of an emergency. The alarm was activated during our inspection and staff responded in a timely manner.

Safe staffing

There was a total of 40 substantive staff employed at Cygnet Lodge Brighouse, and a further 6 therapy staff who worked across Cygnet Wyke Hospital and Cygnet Lodge

Long stay/rehabilitation mental health wards for working age adults

Good

Brighouse on set days. The consultant psychiatrists worked at Cygnet Lodge Brighouse and another Cygnet Hospital in the locality. Cygnet Wyke Hospital is a local sister hospital within a three mile radius of Cygnet Lodge Brighouse. The hospital manager, clinical services manager, lead clinical forensic psychologist, Mental Health Act administrator and head of maintenance were based at Cygnet Wyke; however they attended Cygnet Lodge Brighouse whenever required.

The ward manager used a staffing tool to establish how many qualified and non-qualified staff was required. The tool based its staffing levels on the number of patients admitted onto the ward. At the time of the inspection there were 17 patients, and the staffing levels reflected the tool. This included two qualified nurses and four non-qualified support workers on a day shift, and two qualified nurses and two non-qualified support staff on a night shift. In addition there were therapy staff who worked during the day. The staffing tool did not take into consideration the acuity of patient illness, for example a patient may require one to one observation due to becoming unwell. However, the ward manager felt confident in being able to deviate from the staffing tool in order to increase staffing levels and gave examples of where this had been done.

Cygnet Lodge Brighouse offered its staff, 44 hours, 38.5 hours, 33 hours and 22 hours contracts. The hospital had employed nine full time nurses, with one full time vacancy. The hospital had employed 18 full time health care support workers with two full time vacancies.

The use of bank and agency staff was low. The hospital utilised their bank staff as a priority and the deployment of agency staff was a last resort. When agency staff were required, the service used regular agency staff to cover any shifts that required filling which provided better continuity of care.

Bank and agency staff underwent a full induction as regular employed staff to ensure they were familiarised with the service. In the three months between September 2017 till November 2017, 121 shifts, 13% were filled by agency staff and 4% of shifts, 37, were filled by bank staff. There were no shifts not filled by bank or agency staff in the last six months.

Sickness levels were 9.7% in the last 12 months and there were 13 substantive staff who left in the same period. We were told at least four staff left to progress their careers after gaining experience working at Cygnet Lodge Brighouse.

Nursing staff and health care support workers were visible on the wards engaging in patient activity and one to one discussions. Each patient had dedicated one to one time with a nurse at least twice a week. We saw evidence in the contemporaneous care notes of all the one to one engagement nurses had completed with the patients.

Staff told us Section 17 escorted leave was not cancelled regularly, as it was always planned. The ward manager and other staff felt as though there were enough resources in place to enable Section 17 leave. However, the ward manager informed us in the event of an emergency, leave may be delayed or moved, though this was rare. We were given an example where a patient had to be taken to accident and emergency, which resulted in another patient's leave being delayed due to the staffing. Section 17 leave is the only legal means by which a detained patient may leave the hospital site. The service did not capture how often Section 17 leave was changed or cancelled. Patients did not raise any concerns about their leave or therapeutic activities facilitated by the hospital being cancelled or moved.

The hospital had a Registered General Nurse employed to work across Cygnet Lodge Brighouse and Cygnet Hospital Wyke, as well as staff trained to carry out phlebotomy and to take electrocardiograph readings. This meant the hospital did not have to rely on external services to undertake basic physical health tests.

Cygnet Lodge Brighouse had two consultant psychiatrists who attended one ward round a week each; they worked Monday to Friday across both Cygnet Lodge Brighouse and another Cygnet hospital in the local area. In addition they had an associate specialist doctor who worked Monday till Wednesday and a staff grade doctor who worked between Wednesday and Friday. The hospital had an on call doctor available out of hours, as well as a manager and a senior nurse. Staff felt there was sufficient cover in the event of an emergency.

Prior to the inspection we asked the service to provide us with evidence of staff training. Cygnet Healthcare Ltd had a training compliance target of 95%. Staff carried out

mandatory training in twenty areas which included: basic and intermediate life support, food hygiene, infection prevention and control, information governance, the Mental Capacity Act and Deprivation of Liberty Safeguards and the Mental Health Code of practice. We found the hospital had a completion rate of 90% and above.

The Mental Health Act training module was the only one with compliance below 75%. Fifty-seven percent of the qualified staff required to complete it had done so. The hospital changed its Mental Health Act training in November 2017 from an eLearning module to a classroom based training session facilitated by an external company. At the time of the inspection not all staff had been able to attend due to ensuring there were sufficient qualified staff to provide care and treatment on the wards. However, the ward manager had made alternative arrangement to ensure staff received this training.

Assessing and managing risk to patients and staff

We spent time during the inspection reviewing the provider's staff training package for 'preventing and managing violence and aggression'. The provider used the 'West London mental health NHS Trust' manual for training staff which was developed by providers of care to patients in high secure hospitals. The on-site managing violence and aggression trainer had annual refreshers on this model and used this teaching with staff and the model is used across Cygnet Health Care Ltd.

Staff confirmed that they had been taught high level restraints which included pain compliance techniques, but told us that they could not recall using them. They told us that they would always be a last resort in a life threatening situation, this was in line with the Mental Health Act Code of Practice. We did not see evidence in the records reviewed during the inspection that any incidents of restraint had used restraint holds that would have met the threshold for pain compliance.

Between May 2017 and February 2018 there were 17 incidents of restraint on six different patients. Staff told us these were primarily low level guiding or redirecting patients. Staff recorded each instance of restraint on a post restraint log which identified the level of restraint, observations done after and circumstances in which it happened. There were no incidents of restraint in the six months prior to our inspection.

The provider had recently implemented an audit on the use of restraint, including identifying the levels of holds used. The first audit completed in February 2018 showed that in the last 12 months there were two instances where it was unclear what levels of holds were used as there was insufficient detail on the post restraint log. This audit was to be completed monthly and discussed in the monthly clinical governance meetings, where the findings would be disseminated and discussed in team meetings and supervision to ensure learning was identified and action was taken. Action to be disseminated from this recent audit was to ensure that staff completed the log in sufficient detail to be able to identify the holds used and the reason why. Staff and patients did not raise any concerns around the use of pain compliance and the ward manager assured us this level of restraint was not required in the service.

Staff at Cygnet Lodge Brighouse were also trained in prone restraint. Prone restraint is a physical restraint where a person is placed facing chest down to the ground. There was one incident of prone restraint recorded in the last 12 months. Staff used this in accordance with National Institute for Healthcare Excellence guidelines. The post restraint documentation had been completed accordingly and staff received a debrief after the incident. Apart from this isolated incident, staff told us they do not practice prone restraint routinely. The ward manager told restrictive practice is used to a minimum due to the service type. All admissions were planned and there was an admission criteria which meant patients who were acutely unwell or had significant risks could not be admitted onto the ward. This reduced inappropriate admissions and the risk of staff using prone restraint.

There were three types of prevention and management of violence and aggression training staff had to undertake including an introduction, a three day course and a refresher. The service had over 95% for all three types. Staff told us they prioritised verbal de-escalation when managing challenging behaviour and felt they were skilled in doing so. Staff felt that verbal de-escalation was successful in most cases. Through our observations we saw staff had a good rapport with patients; the atmosphere within the hospital was calm and the ward had a homely feel.

There was no use of rapid tranquilisation or seclusion in the last 12 months.

Long stay/rehabilitation mental health wards for working age adults

Good

Staff did not use blanket restrictions. A blanket restriction is a rule which a provider puts into place for all patients for all patients regardless of their risk level or detention status. Prior to admission staff completed a search agreement with the patient. Patients were searched on admission and then from that point all searches were completed if staff had concerns around a specific patient which was based on risk, and this would be reflected in a risk assessment and care plan. Prior to any decisions being made it would be discussed in a multidisciplinary meeting. For example, if a patient was suspected of bringing contraband onto the wards then a discussion would be conducted in the multidisciplinary meeting whether it was necessary to search the patient.

All patients who went on leave had a photo taken of them at reception. This was only done with their consent. It meant staff had an up to date descriptor of the patient in the event of an emergency or if the patient went absent without leave.

Staff at Cygnet Lodge Brighouse used the Short-Term Assessment of Risk and Treatability risk assessment tool. This recognised tool required staff to score patients on key risk indicators such as 'violence to others' and 'suicide', identify key historical risks and develop a formulation. The final part of the assessment looked at how hospital staff would manage the risks.

The hospital used other specialist risk assessments for patients who required them, they included, the 'Historical Clinical Risk 20' and 'Risk for Sexual Violence Protocol'.

We reviewed six out of 17 patient care records and found all six patients had an up to date risk assessment which was regularly reviewed. We saw examples in the contemporaneous notes where patients risk had increased, and this was subsequently reflected in the most up to date risk assessment. Risk assessments were comprehensive, detailed and demonstrated staff understood what current and historic risks affected the patients. We found risks were regularly discussed during ward rounds and multi-disciplinary meetings; this was reflected in the minutes and the care records.

Child safeguarding and adult safeguarding was part of the mandatory training within the hospital. There was a high completion rate for both. Staff understood their responsibilities in relation to safeguarding and knew the correct protocols in making a safeguarding referral. The ward manager told us the hospital had a good relationship with the local authority. They were able to offer support and advice to the hospital if and where required.

Children were allowed to visit the hospital, and there was a provider policy to support this. Children could only use the family lounge which was opposite the main entrance. This meant children and families would not have to walk through patient areas. All children visiting the hospital had to be accompanied by an adult at all times.

We checked the arrangements for managing medicines on the ward. The provider had a medicines policy which covered all aspects of medicines management. We reviewed the provisions for managing controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and found they were stored securely on the ward with access restricted to authorised staff. The accountable officer was the clinical manager. Medicines were stored in a treatment room and access was restricted. Key information was documented on each shift during the handovers. Fridge temperatures were monitored daily and were within recommended ranges.

The hospital had an agreement with a local pharmacist who attended the ward weekly, and completed medication audits. The pharmacist also offered additional support to staff in medication reconciliation and supported patients if they had any questions or concerns in relation to their medication.

We discussed prescribing practices with the lead consultant psychiatrist for the service. Doctors had prescribed some patients more than one anti-psychotic medication, and some doctors prescribed over recommended British national formulary limits. The consultant psychiatrist explained that all doctors within the hospital took part in an audit of prescribing practice to monitor this. They also said that the multi-disciplinary team meetings discussed the use of medication above limits to continually review the potential risks against the benefits of the medications prescribed. They felt assured that staff had undertaken regular physical health checks with these patients.

Track record on safety

There were 12 serious incidents in the last 12 months. Of the12 incidents more than 50% were in relation to a high

Long stay/rehabilitation mental health wards for working age adults

Good

number of absent without leave over a short period of time. This was due to an issue with one of the doors leading outside. The hospital recognised this and invited local fire service to review the building to see what could be done to ensure patient safety but keep the access in and out of the building for fire safety regulations. As a result they changed the door frames to make them more robust. This meant patients could not push through the door as they could before. In addition, the hospital developed a positive relationship with the local police due to the regular call outs each time a patient went absent without leave. This resulted in the police attending the ward on a monthly basis to spend time and engage with patients. The monthly visits were informal, but allowed the police to engage with patients. In this way, the hospital demonstrated that they were able to learn and improve their practice as a result of these incidents.

Reporting incidents and learning from when things go wrong

All staff were able to report incidents using a paper based incident recording and reporting system. Ward managers and the clinical manager reviewed all incidents.

If incidents met serious incident criteria ward managers completed 24 hour and 72 hour reports. The corporate risk manager reviewed these and decided whether a full investigation and root cause analysis were required. An external case manager completed the investigation and root cause analysis within 20 days of the date of the incident. The external investigation manager shared the final serious incident reports at monthly governance meetings. The clinical manager oversaw any actions required from reports in via the services' 'overarching local action plan'.

Staff regularly received debriefs after incidents and felt well supported by more senior members of staff. The hospital had set debrief sessions after serious incidents. Learning lessons from incidents was fed back to staff on different platforms, including team meetings, electronically or through debriefs.

The Duty of Candour is the responsibility of the hospital to be open, transparent and honest with patients and carers when things go wrong. The ward manager provided us with examples of how the service acted within the Duty of Candour. A patient had an administration error with their mental health act paperwork and although this had no direct impact on their care the ward manager informed the patient of the error verbally and provided a written explanation with an apology.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

All admissions to the hospital were planned. Prior to admission, a comprehensive pre-admission assessment was completed with the patient by the ward manager and another qualified team member.

Cygnet Lodge Brighouse based their care plan documents on the 'recovery start'. All patients had a recovery care plan and a care plan around their safety. For additional needs such a physical health issues, extra care plans were put in place.

We reviewed six out of 17 care and treatment records. Care plans were detailed, comprehensive and future focused. Staff used specific, measurable, attainable, realistic and timely objectives as part of the goal setting. Staff regularly reviewed care plans and updated them.

We saw good evidence of physical health monitoring at the hospital. All patients had a physical health check done upon admission. This included blood tests, electrocardiogram readings, height and weight measurements. Staff regularly monitored physical health during the weekly ward rounds and multidisciplinary meetings. Patients who had physical health difficulties had separate care plans to reflect this. The hospital had established strong relationships with the local health economy. All patients at the hospital were registered to a local general practitioner and we saw examples of patient's accessing other services such as the opticians. The hospital also had employed a registered general nurse to oversee physical health who worked at Cygnet Lodge and Cygnet Hospital Wyke.

Long stay/rehabilitation mental health wards for working age adults

Good

All care records were paper based. Patient records contained all the relevant information, were easily navigable and well maintained. They were stored securely in a locked room. All staff could access patient records when required.

Best practice in treatment and care

Staff followed best practice in delivering care and treatment for its patients. Staff told us they used guidance from the National Institute of Health Care Excellence, the Royal College of Psychiatry the Department of Health, and the Nursing and Midwifery Council, as well as the Mental Health Act Code of Practice to support their practice.

Cygnet Lodge Brighouse used a three stage 'psychological assessment and treatment pathway' for the delivery of psychological interventions. Stage one was the assessment stage; patients had to undergo one of four types of assessments depending on their history. It included violence risk assessment (Historical Clinical Risk 20, HCR-20), sex offender risk assessment (Risk for Sexual Violence Protocol), personality assessments (Hare Psychopathy Checklist Revised), and a range of neurological assessments and or psychological formulations. We found in most cases patients always had at least a psychological formulation in place. Stage two was based around therapy, which included group sessions such as coping skills, social skills, problem solving, creative thinking and keeping safe. It also included one to one sessions consisting of, cognitive behavioural therapy, dialectical behaviour informed therapy, schema informed therapy and solution focused therapy. The final stage related to 'change' with work around offending behaviour (for patients with a forensic background).

The hospital had a lead clinical forensic psychologist, a forensic psychologist, and a trainee forensic psychologist to support the delivery of the therapeutic interventions. The ward manger informed us there was no waiting list for patients to start receiving psychological therapies. Staff were also able to deliver low level psychotherapeutic interventions.

Patients had a physical health checks completed on admission, including blood tests, electrocardiogram readings, height and weight measurements, and staff regularly monitored physical health. Patients were supported to access the local GP and other physical health appointments. Staff used the Malnutrition Universal Screening Tool to help them monitor nutritional intake. We saw evidence that staff reviewed patient's nutrition and hydration where appropriate.

Staff used a range of recognised rating scales and screening tools, in order to identify key issues which impacted on patient health and to monitor progress. These included,

- Health of the Nation Outcome Scales
- Tinetti balance assessment tool
- Model of Human Occupation Screening Tool
- Camberwell Assessment of Need Short Appraisal Schedule
- Drug and alcohol screening and assessment tool.
- Multi-Agency Public Protection Arrangement screening tool.

The service undertook a variety of audits to monitor the quality and safety of the service. The hospital had an annual clinical audit programme which included audits of the following areas completed by senior staff:

- annual overview of prescribing and administration errors
- prescribing habits audit
- high dose anti-psychotic audit
- clinical file audit
- physical health audit
- section 5(2) audit
- safeguarding referral audit
- child visit and social work audit
- audit of the quality of tribunal reports

Staff undertook clinical audits in order to identify gaps within the service and continuously drive improvement, for example case note audits, Mental Health Act audits, and physical heath audits. The ward manager said the service had improved their audits to quality audits as opposed to 'tick box audits'. This meant staff would also describe the types of issues they were seeing and made the audit more

Skilled staff to deliver care

The hospital had a full range of multidisciplinary staff including; registered mental health nurses, psychologists, occupational therapists, substance misuse workers, health care support workers, a social worker, psychiatrists, an art therapist, and a music therapist. The hospital had also employed a registered general nurse to support patients in

managing their physical health who worked at Cygnet Lodge Brighouse and Cygnet Hospital Wyke. An external pharmacist attended the hospital on a weekly basis to support staff, patients and medical professionals.

Staff were experienced and qualified to undertake their roles. We reviewed five staff personnel files as part of our inspection activity. All files contained suitable references and pre-employment checks. Disclosure and barring service checks had also been completed.

All staff had had an appraisal in the last 12 months. The service had an appraisal season where all staff had to complete their appraisals within a set period of months. This meant the service was assured staff were having their annual appraisals and enabled the ward manager to effectively plan for them.

The provider had a clinical supervision target of 90%. Staff were receiving regular monthly supervision. Staff also attended monthly team meetings and daily hand overs. Staff told us they felt adequately supported and told us they could undertake additional specialist training to enhance their skills if it was beneficial to their role. For example, some health care support workers had been trained in phlebotomy.

The ward manager felt confident and supported to address poor performance where necessary, and provided examples of how they supported staff who had been identified as not performing.

Multi-disciplinary and inter-agency team work

Handovers took place twice daily as part of the staffing shift change. Key information was typed up as part of a handover sheet and included changes to allocated leave, patient observation levels, and risk. Staff told us the handover system worked well; it kept them informed of changes to patients risk and wellbeing before commencing shifts.

We observed one multi-disciplinary meeting which was unplanned and set up as a matter of urgency. Although the nature of the meeting was challenging, we found it was well facilitated, patient focused and comprehensive. The meeting had a full complement of staff including relevant professionals and external stakeholders such as care coordinators. The psychiatrist led the meeting and there was active participation from all the attendees, as well as the patient, and their carer.

The hospital had working partnerships with external stakeholders such as the local general practice, local authority safeguarding team, police, ministry of justice, commissioners, physical health specialists and a local pharmacy.

Adherence to the MHA and the MHA Code of Practice

At the time of our inspection 57% of staff had completed their mandatory training in the Mental Health act and the Mental Health Code of Practice. The service had implemented a new classroom-based training for the Mental Health Act in November 2017. The service had prioritised training all qualified staff first. Although the training figures were low, staff both qualified and non-qualified demonstrated good working knowledge of the Mental Health Act and knew where to go if they needed further support.

Staff regularly informed patients their rights upon admission and thereafter on a monthly basis.

The service had an on-site Mental Health Act administrator. Staff knew who this staff member was and told us that they were accessible and offered advice and guidance to staff.

The Mental Health Act administrator had oversight of admission paperwork, monitored the dates for patient's tribunal meetings and renewals, and provided reminders to psychiatrists when action was required. They also completed regular audits of paperwork to ensure it was correct and complete, and that staff were applying the Act appropriately. The administrator and their assistant were well qualified for their role and had robust systems and processes in place. The corporate lead for the Mental Health Act was based at Cygnet Hospital Wyke and was also available to provide guidance and support.

We reviewed the provider's policy 'for the administration of the Mental Health Act' (2016). The Mental Health Act manual for staff sat alongside this policy. The policy referenced relevant legislation including the Mental Health Code of Practice (2015).

Detention paperwork was completed accurately and was up to date in all records reviewed. Historic copies of section 17 leave forms had been archived to prevent confusion and to enable an audit trail if required. Consent to treatment documentation, T2 and T3's was attached to the

medication charts and had been filled in accordingly. All patient files had a copy of their detention paper work, including the Approved Mental Health Act Practitioners report.

We found the hospital was not monitoring how much section 17 leave was being cancelled or changed. This meant they were not able to monitor trends which may identify gaps within the service such as staffing levels. Patients and staff told us leave is rarely cancelled; however it may be moved to a different time or reduced in time depending on the acuity on the ward.

Patients were able to access independent mental health advocacy services provided by a local organisation, this was in accordance with the 2015 Mental Health Act Code of Practice. The hospital had two regular advocates assigned to them who attended the ward on a weekly basis. All staff and patients knew who the advocates were and we saw examples of patients regularly utilising advocates during multi-disciplinary meetings.

Good practice in applying the MCA

The Mental Capacity Act is legislation that maximises an individual's potential to make informed decisions wherever possible. The Act and associated code of practice provide guidance and processes to follow where someone is unable to make capacitated decisions.

At the time of our inspection most staff had received training in the Mental Capacity Act and had a compliance rate of 90%. Staff that we spoke with during our inspection had a variable understanding in the Mental Capacity Act. Staff had an understanding of the five principles of the Mental Capacity Act. They were confident in discussing least restrictive practice. However, staff had less understanding of how to assess capacity and to facilitate best interest decisions.

We reviewed the provider's policy for the Mental Capacity Act (2016). The policy was thorough and explained the principles of the Act and contained relevant guidance including updates from the 2014 supreme court judgement in relation to Deprivation of Liberty Safeguards.

There were no patients subject to the Deprivation of Liberty Safeguards. These safeguards make sure that people in hospitals are looked after in a way that does not inappropriately restrict their freedom. They set out a process the provider must follow if they believe it is in the person's best interest to deprive them of their liberty in order to provide particular care.

We saw examples within the contemporaneous records and the multi-disciplinary notes where staff were having discussions around capacity, and whether a capacity assessment was required, however, we did not see any specific capacity assessments or best interest decisions made.

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

Good

Kindness, dignity, respect and support

We observed kind and compassionate care at Cygnet Lodge Brighouse. Staff were engaging with patients in activities and were visible on the wards. Staff were responsive in addressing concerns, where patients were upset or feeling unwell, staff responded in a timely way.

We spoke to nine out of 17 patients, all of whom were positive about staff at the hospital. Patients told us, they felt safe at the hospital. Patients felt listened to and felt staff understood their needs. They felt well informed of their care and gave us examples of how staff explained information about their medication, purpose and potential side effects.

Patients told us staff always had time to speak to them and they felt listened to. They felt staff were supportive and had the patients interests at heart.

We reviewed the compliments folder held by the ward, which included notes, cards and electronic feedback from patients and carers on the ward. Patients commented on how well staff looked after them and how hard working staff were. One comment complimented staff on how well they advocated their views during meetings.

The involvement of people in the care they receive

Long stay/rehabilitation mental health wards for working age adults

Good

We reviewed six care plans all of which were individual to the patient. Although care plans were written in a formal tone and not always in a patient's own words, they had been done in collaboration with, and signed by, the patients.

We saw good evidence of patient and carer involvement within multi-disciplinary working. We observed a multidisciplinary meeting which was patient led, and where the patient had difficulty communicating their thoughts and feelings their advocate supported them appropriately. The meeting was patient focused and staff ensured the patient remained at the centre of the discussion.

Patients were able to give feedback on the care and treatment they received in a number of ways. This included informal discussions about how patients would like the wards to be decorated, as well as more formal weekly patient community meetings. Outcomes were presented on a 'you said we did' we did board in the communal lounge of the ward.

We spoke to three carers, all of which were very positive about the care and treatment their family members received at Cygnet Lodge. They felt staff were supportive, caring and knowledgeable in their roles and they felt involved in their relative's care and treatment. Although we saw the service was working closely with families and carers, staff did not reflect the views of family and carers within the care plans or risk assessments.

All patients were given a welcome gift on admission to help them settle onto the ward. It was agreed with them prior to their arrival and included things such as a DVD player, or a television. The ward manager said this was so the patients would feel welcome and less anxious about coming into a new environment. Examples were given where patients were brought DVD players, clothes or televisions.

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

Good

Access and discharge

All patients had planned admissions onto the ward. The ward manager and another qualified member of staff completed the pre-admission assessment where they checked to see if Cygnet Lodge Brighouse could meet the needs of the patient. The assessment also enabled the team to understand any issues around risk they could plan for upon admission.

At the time of the inspection there were 17 patients admitted onto the ward at Cygnet Lodge Brighouse. The hospital accepted referrals for patients from around the country including from Kent and Leamington Spa, as well as from more local areas such as Leeds and Bradford. The service had a set referral criteria to ensure that patients were suitable to receive care and treatment at Cygnet Lodge.

In addition, Cygnet Lodge Brighouse had three beds which were commissioned by another NHS trust. The hospital had a service agreement named 'discharge to assess' which was a 12 week rehabilitation admission for patients coming from acute or forensic settings who were working towards discharge. Its aim was to prepare and integrate patients back into the local community within 12 weeks. It was a structured pathway which enabled patients to step down into a more independent rehabilitation environment as their community care package was being formulated.

We found discharge planning was well embedded within multidisciplinary meetings and patient records. In the last 12 months the service discharged 11 patients back into the community. The average length of stay was just under 12 months. The average length of stay for patients in rehabilitation units can be between one and three years.

All admissions and discharges were planned. This meant patients were transferred to and from the hospital at an appropriate time. There was one delayed discharge in the last 12 months; this was as a result of a placement not being available at the point of discharge. The ward manager said this was the most common cause of delayed discharges. The ward were proactive in working with community provisions to reduce delayed discharges.

In the event a patient became acutely unwell, the hospital would transfer the patient to the local trust's acute ward or psychiatric intensive care unit. Cygnet also had their own

acute and psychiatric intensive care unit available locally if there was no availability at the trust. In the last year one patient was moved back into an acute ward due to a deterioration in his presentation.

The facilities promote recovery, comfort, dignity and confidentiality

There were a good range of facilities to support patients during their rehabilitation. Patients had access to large communal lounge, as well smaller lounges if they wanted their own space. There was an internet room, as well a television area and an area to play pool. There was a large visitors' room with a library, which could be used as patient area if there were no visitors. Patients had access to a multi-faith room which had scriptures from different religions and provided a safe space for spiritual reflection or to practice their faith. There was sufficient outdoor space and patients had a horticultural area where they could grow fruit and vegetables.

The hospital had a three flat-lets on its top floor. This comprised a shared kitchen and lounge with three separate bedrooms with en-suite bathrooms. These flat-lets had been designed for patients who were nearing discharge and who were ready for more independence. The patients in the flat-lets cooked their own meals, learnt basic life skills, and had a shared responsibility for the flat-let's communal areas. We found good examples of communal living where patients had pooled their finances for the food shopping. Due to the success of the flat-lets, the ward manager told us the hospital had secured funding to create another three flat-lets within the hospital.

There was a separate telephone room for patients to make any calls. This room optimised privacy as it was closed off to the rest of the patients. Patients could access drinks and snacks 24 hours a day.

Patients contributed to how they wanted to the hospital look. For example, a graffiti wall was proposed in one of the lounges but the patients wanted posters instead so the service changed the wall accordingly. Patients contributed to how the corridors were painted and decorated throughout the hospital. Patients were able to decorate their bedrooms to their own individual taste and the bedrooms we saw were unique to the patient. The ward spaces were homely and did not feel like a clinical environment.

All patients had daily activity planners which included in-house activities, as well as activities within the community. We found examples of patients undertaking voluntary and paid work within the local area. The activities coordinator facilitated weekend activities like day trips and visits to coastal towns; these were chosen by the patients during community meetings. Other activities included, Gym sessions, pool and snooker, cooking classes and other community based provisions.

Meeting the needs of all people who use the service

Cygnet Lodge Brighouse had three floors. Access to the hospital was on the first floor. The hospital had lift access to all the floors which meant patients with mobility issues could access all areas of the hospital. There were two disability access rooms for patients with disabilities or mobility issues. These were located on the first floor near the entrance. The hospital had emergency evacuation equipment for patients who would require them in the event of an emergency such as a fire.

A range of information leaflets were available for patients and covered topics including patients' rights, local advocacy services, complaints leaflets and activity timetables. The service had displayed the ratings from their previous CQC inspection, certificates and achievements.

The hospital was able to accommodate patients' dietary needs according to their religious, spiritual or cultural preference, and patients had a choice of food at meal-times. The ward manager told us they could arrange access for spiritual support for patients where required. A chaplain visited the hospital on a weekly basis. We saw examples of patients accessing spiritual support outside of the hospital, such as going to the church or a mosque.

Listening to and learning from concerns and complaints

The hospital had four complaints in the last 12 months. None of the complaints were upheld or partially upheld. Two complaints were against other patients, one was against a member of staff, and the final complaint was in relation to a patient's finances. The service worked with the complainants to resolve their concerns in a timely way before the formal process was required. The complaints investigations undertaken by staff followed Cygnet policy

Long stay/rehabilitation mental health wards for working age adults

Good

and procedure. In each complaint staff sent an initial response to the complainant within five working days and a final response within 20 working days. All complaints we reviewed had met this target.

Patients received information on how to complain on admission and there were posters around the ward. The poster provided patients with the details of the Care Quality Commission, as well as flow charts describing how their complaint would be dealt with. The first flow chart showed how patients could resolve their issue informally. The second flow chart showed how patients could make a formal complaint if they didn't feel they could talk to staff members on the ward. Patients we spoke to were aware of how to make a complaint and felt they would be able to if required.

The team leader said all complaints or issues would be resolved informally where possible; however if the patient wanted to pursue a formal complaint then they would be supported to do so. Staff corroborated this, and said issues would be dealt with locally unless the patient wanted to make a formal complaint. The ward manager received all formal complaints, triaged them, and allocated them for investigation. The hospital manager and operations director were responsible for investigating complaints.

Learning from complaints was communicated to staff electronically via email or during staff meetings and handovers.

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

Good

Vision and values

Cygnet Healthcare Ltd had an overall vision to be the 'provider of choice'. The local hospital strategy was 'to provide superior quality healthcare that; service users recommend to family and friends, clinicians prefer for those in their care, commissioners first choice for their service users and employees are proud to work for".

The values of the provider were:

- Helpful
- Respectful
- Honest
- Empathetic
- Responsible

The service displayed the values throughout the hospital. The majority of staff we spoke with were able to describe the values.

At a ward level staff were encouraged to discuss the values of the organisation in supervision, team meetings, and through the appraisals process.

Staff knew who the most senior managers in the organisation were because they visited the hospital on a six monthly basis for governance meetings.

Good governance

The hospital had a clear governance structure in place. On a monthly basis all senior staff from ward manager level met for clinical governance meetings. A standardised agenda was discussed which included; actions from the previous meeting, an advocacy presentation, medication management, compliance with the Mental Health Act, risk management, serious incidents, restraint, seclusion, safeguarding, serious incidents, audit outcomes, areas of concern, compliance and regulation, quality assurance updates, therapies, physical health, complaints and compliments.

Since August 2017 the hospital had begun to focus governance into ward level. On a monthly basis each ward manager received a data pack. This included information regarding areas such as incidents, restraints, prone restraints and complaints and compliments. There was an expectation that each ward manager would present this information to the governance meeting and discuss actions for example in regards to reducing incidents of restraints. We were able to see that this was taking place.

On a six monthly basis the senior leadership team met with the board and corporate managers. Meetings took place on site and followed the same format as local governance to ensure the meeting followed up issues and concerns from a local level.

Governance structures were effective and well established. Staff were appraised and supervised and had opportunities for additional training and development. The service

planned and managed staffing well, and the ward manager ensured that the ward ran with safe levels of staffing. Overall compliance with mandatory training was high. The hospital achieved an average of 90% completion.

Staff undertook regular clinical audits to identify gaps within the service and drive improvement, they included medication audits, patient record audits and Mental Health Act Audits. There was continuous learning from incidents, the service was identifying themes and trends and addressing them in a timely manner.

The provider actively sought feedback from patients, carers and staff about the services the hospital provided. There was a thorough and detailed plan of ward level and hospital wide audits to monitor and improve safety. There were thorough and detailed processes in place in relation to the management of the Mental Health Act.

At ward level there were opportunities for staff to learn from incidents and because team meetings, supervision and debrief were taking place and staff told us that they felt supported.

The service worked to several key performance indicators to measure safety and quality, these included; sickness, training, supervision and appraisal, complaints, safeguarding, serious incident reports, restraint and compliance. The service measured their performance against other Cygnet hospitals to indicate any areas in which the hospital was an outlier.

The hospital had a local risk register in place which fed into the corporate level risk register. There were two risks on the local risk register which included the recruitment of qualified nurses and physical healthcare GP provision for patients. The hospital manager updated the risk register on a monthly basis with notes of actions taken each month. Managers could escalate concerns to the corporate risk register after discussion with the corporate risk manager. There were no local concerns from the hospital entered on the corporate risk register. Although the corporate risk register contained items which would be a risk for the hospital such as; staff recruitment and retention, high dependency on agency workers, competitors, suicide and self-harm, failure to manage staff stress, high use of restrictive practices, and primary healthcare.

Although the use of restraint overall was very low at this service because patients on this ward were generally settled and their level of acuity was low (there had been 17 incidents of restraint with six patients in the 12 months prior to the inspection). However, staff did not always provide sufficient detail in their restraint recordings to identify the level of holds they had used in restraint. This meant that the provider did not have assurance that the level of restraint used was appropriate. The audit to address this had been recently introduced.

Leadership, morale and staff engagement

There was a strong team ethic and a positive working culture during the inspection. Staff morale was good and they were committed to their roles. Staff told us they felt valued listened to. Staff felt supported by local management and that they could raise concerns without fear of victimisation or reprisal. Although the hospital manager and clinical manager were based locally at a sister hospital, the ward manager felt well supported by management and felt as though she had enough autonomy in her role to carry it out effectively.

Cygnet Ltd offered its staff opportunities to develop themselves and gain management and leadership qualifications. This offered the opportunity for staff to upskill themselves and for Cygnet to retain staff. The qualifications ranged from basic National Vocational Qualifications in health care to routes into management training. Qualifications included :

- Team Leading Level 2
- Team Leader Supervisor Level 3
- Hospitality Team Member Food Preparation Level 2
- Health care Support Services Level 2 and 3
- Adult Care Worker Level 3
- Care Leadership and Management Level 5

Patients selected an the ‘employee of the month’ and the employee was given a voucher as part of their achievement.

Cygnet Lodge Brighouse shared their staff survey results for 2017. Staff were given the opportunity to feedback different elements of their employment and how they would like to see things improve. These results were collated as an organisation to understand how staff were feeling and how changes would be addressed.The results for last years’ staff survey demonstrated eight out of 10 employees felt their manager took an interest in their wellbeing, and nine out of

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Good

10 staff felt their manager treated them with respect. One of the key changes made as a result of the staff survey was the move towards an electronic care record system as staff had voiced their concerns about paper record keeping.

Staff were aware of whistleblowing and who they could go to raise concerns. The provider had a 'whistleblowing policy' to support staff in raising concerns. Individuals could raise concerns within the hospital or externally.

Commitment to quality improvement and innovation

Cygnet Lodge Brighouse were participating in the Accreditation of Inpatient Mental Health Services for rehabilitation services. This is a quality network for mental health rehabilitation services works with services to improve the quality of inpatient rehabilitation wards. It engages staff, service users and carers in a comprehensive process of both self-review and peer-review for the purpose of quality improvement and accreditation. Good practice and high quality care are recognised and services are supported to identify and address areas for improvement.

The ward manager said she was always looking to improve the service and was involved in various mechanisms to drive improvement. For example, she attended a "Reducing restrictive practice for the North" group where all the managers at Cygnet shared good practice.

Cygnet Lodge Brighouse had good relationships with two local universities and were involved in providing work placements for student nurses and delivering seminars. At the time of the inspection the hospital had three preceptor nurses and two student nurses. The ward manager felt their up to date skills and knowledge was beneficial as it brought a fresh perspective to the ward.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure staff have a good understanding of the Mental Capacity Act, in particular, capacity assessments and best interest decisions.
- The provider should ensure that staff record sufficient detail in the restraint logs to provide assurance that restraint, including pain compliance, is used in line with the Mental Health Act code of practice.
- The provider should ensure it continues to support staff complete the new Mental Health Act module.
- Staff should ensure care plans are written in the patients' own words andthe provider should ensure families and carers views are represented within care plans.