Cygnet Surrey Limited

Cygnet Hospital Woking

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Cygnet Hospital Woking is an independent mental health hospital run by Cygnet Surrey Limited. The hospital offers a range of mental health services for men and women across four wards.

Our rating of this location went down. We rated it as requires improvement because:

- Staff did not ensure that patients who were administered rapid tranquilisation were properly monitored. For example, we did not see post dose physical health monitoring for three patients who were administered rapid tranquilisation on the Acute and PICU wards. For service users with physical health needs, their care plans were not always detailed enough and did not always contain important follow up information. We also did not always see that appropriate monitoring required by prescribed treatment was in place to review the effects of each patient's medication on their physical health. We also did not always see that appropriate stool monitoring required by a prescription of Clozapine was in place to review potential effects on patient's physical health on Oaktree ward.
- Staff did not ensure clinic rooms and fridge temperatures were maintained to ensure medicines were kept safely within their specified temperature range on the acute and PICU wards. For example, we found that temperature records of clinic rooms were regularly above 25°C but no action had been taken to reduce the temperature or check the impact this had on medicines effectiveness.
- We found concerns with the monitoring and management of medical equipment. On the Forensic inpatient or secure wards, there were out of date items in the emergency bag and oxygen cylinders were not stored securely. The service also did not always ensure the safe management of healthcare waste. On the acute and PICU wards staff did not ensure that the blood glucose monitoring machine was properly calibrated.
- Staff did not ensure that all patients had copies of their care plans on the acute and PICU wards. Some patients told us they had requested copies of their care plan for weeks and staff were yet to give them their care plans. Care plans on the forensic wards did not always capture the patients strengths.
- Staff on the acute and PICU wards did not ensure that patients prescribed rapid tranquilisation had a care plan in line with the organisation's policy. In addition, there was not always a clear and detailed management plan for diabetic patients and patients admitted with low BMI in line with national guidance.
- Staff did not always understand the rights of informal patients and they recorded information incorrectly. For example, staff on the acute and PICU wards were recording in progress notes that informal patients utilised section 17 leave when this only applies to detained patients.
- The provider did not always provide feedback to patients when they raised concerns or issues on the forensic inpatient or secure wards. Patients told us that they did not receive updates to issues raised and we saw that community meeting minutes were not always consistent in feeding back on actions taken and "You said, we did" boards on the wards were blank.

However,

- The ward environments were safe and clean. Staff managed patients' risks well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding. Patients reported they felt safe on the wards.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit.
- The teams provided a range of treatments suitable to the needs of the patients and in line with national guidance and best practice. There were several suitable ward-based activities including board games, movie nights, and colouring, as well as therapeutic activities including Cognitive Behavioural Therapy, staying well groups, mindfulness and meditation.

Summary of findings

- The ward teams included or had access to the full range of specialists required to meet the needs of patients including doctors, nurses, support worker, social workers, psychologists and occupational therapists. Staff had access to other clinical specialists including dietitians and speech and language therapists that were external to the service.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. We observed interactions between staff and patients and found them to be warm, helpful and supportive. Patients told us that staff listened to patients and addressed their individual needs and that they felt that staff genuinely cared for their wellbeing.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.
- Leaders had the skills and experience to perform their duties. They engaged actively with patients, staff and local health and social care providers

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	Our rating of this service went down. We rated it as requires improvement because: • Staff did not ensure clinic rooms and fridge temperatures were maintained to ensure medicines were kept safely within their specified temperature range. For example, we found that temperature records for each clinic room were regularly above 25°C but no action had been taken to reduce the temperature or check the impact this had on medicines effectiveness. Staff did not ensure that clinic room cleaning records were kept up to date. • Staff did not always ensure that they completed post dose physical health monitoring for patients who were given rapid tranquilisation. There were no records to show that staff had completed the required monitoring of patients such as blood pressure check, pulse and oxygen saturation. • The provider did not ensure all rapid tranquilisation care plan included the medication and circumstance in which it is to be used and the patient's response to the medication. In addition, there was not always a clear and detailed management plan for diabetic patients and patients admitted with low BMI in line with national guidance. • Staff did not record patients' responses to 'as required' (PRN) medicines which were administered for the management of agitation and aggression in line providers' policy. • The provider did not ensure that the blood glucose monitoring machine was properly calibrated. This meant that the machine may not give accurate blood glucose readings. • Staff did not offer patients copies of their care plans. • Staff did not always understand the rights of informal patients and they recorded

Summary of findings

information incorrectly. For example, staff were recording in progress notes that informal patients utilised section 17 leave when this only applies to detained patients.

- Staff did not consistently maintain patients' privacy. Staff were carrying out physical health observations in communal areas.
- Staff did not always ensure that they followed the admissions protocol to mitigate the risk COVID-19 outbreak.
- Staff we spoke to told us that they were often overstretched because they did not have sufficient staff, and patients on Picasso ward reported it could be sometimes difficult to access qualified nurses
- Managers on Acorn ward did not ensure healthcare support workers received individual line management supervision.
- While most staff felt respected, supported and valued, some staff felt leaders were not always very responsive when they raised concerns, and ward managers were hardly visible on the wards.

However,

- The ward environments were safe and clean. Staff minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- For majority of patients, staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Leaders had the skills and experience to perform their duties. They engaged actively with patients, staff and local health and social care providers

Forensic inpatient or secure wards

Good 

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

- The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding. Individual risk assessments were also carried out to manage any specific risk, for example, kitchen access, possession of bedroom keys and access to computers. Staff on both wards followed the observation policy to ensure the management of patient risk. We reviewed observation records and saw that these were clear, and that the allocation of staff matched the prescribed observation level. Both wards had low use of restrictive practices. Staff were confident in identifying and responding to safeguarding concerns.
- They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. The service provided several therapeutic activities including Cognitive Behavioural Therapy, staying well groups, mindfulness and meditation
- Staff engaged in clinical audit to evaluate the quality of care they provided. The service had a comprehensive audit schedule in place which covered many areas of the service including medication, safeguarding, health and safety, physical health, Mental Health Act and Mental Capacity Act, observation and engagement and Infection, Prevention and Control (IPC). We saw evidence that action had been taken from audit data to ensure improvements were made. The

Summary of findings

service was also involved with the Quality Network for Forensic Mental Health Services and were expecting a peer review the month of the inspection.

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The service had access to clinical staff including ward doctors, GP's, nurses and support workers, and therapy staff including psychologists, occupational therapists, social workers and activity coordinators. Where additional specialists were required, such as speech and language therapists, the service told us that these were accessed externally.
- Managers ensured that staff received training, supervision and appraisal. Managers supported staff through yearly appraisals, quarterly clinical supervisions and monthly managerial supervisions. All staff were up to date with mandatory training.
- The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare. We saw evidence of multidisciplinary involvement in daily entries on patient notes and staff accessing multidisciplinary teams for support and advice. Ward teams had effective working relationships and liaison with external community teams and organisations, for example, care coordinators were invited to attend ward round meetings.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We saw evidence that staff informed all patients of their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Staff made sure patients could take section 17 leave (permission granted to leave the hospital for those detained under the

Summary of findings

Mental Health Act) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. We observed interactions between staff and patients and found them to be warm, helpful and supportive. Patients told us that staff listened to patients and addressed their individual needs and that they felt that staff genuinely cared for their wellbeing.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason. The service had low numbers of delayed discharges. We saw evidence of involvement from NHS commissioning and Forensic Outreach Liaison Services (FOLS) in patients' discharge. Staff told us that they had positive working relationships with community teams which helped in facilitating discharges.
- Leaders had the skills and experience to perform their duties. They engaged actively with patients, staff and local health and social care providers.

However,

- There were some concerns around the medicines management within the service. For service users with physical health needs, their care plans were not always detailed enough and did not always contain important follow up information. We also did not always see that appropriate monitoring required by prescribed treatment was in place to review the effects of each patient's medication on their physical health.
- There were also concerns around medical equipment and storage. For example, blood glucose monitoring machines were not being consistently calibrated. Without proper calibration the service cannot be assured the

Summary of findings

readings taken on these machines were accurate and that the treatment being offered to patients was appropriate. When temperatures of medicines storage areas were outside of the appropriate range, action was not always taken to safeguard medicines supplies.

- We found concerns with the monitoring and management of medical equipment, for example on Greenacre ward emergency bag and equipment checks were not consistent, there were items which were out of date or unpackaged and oxygen cylinders were not stored securely. The service also did not always ensure the safe management of healthcare waste.
- On both wards, patient paper notes did not always correlate with the electronic records and some of the paper copies were out of date.
- While the seclusion room on Greenacre ward had not been used for four months, we saw that it had issues with privacy and dignity in that it could be viewed from the external ward garden. Managers told us that they were putting in place a fence to prevent the ability to see in through the windows
- The provider did not always provide feedback to patients when they raised concerns or issues. Patients told us that they did not receive updates to issues raised and we saw that community meeting minutes were not always consistent in feeding back on actions taken and “You said, we did” boards on the wards were blank.
- The provider did not always ensure the family members were involved in their relatives care where this was appropriate.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Hospital Woking

Cygnet Hospital Woking is an independent mental health hospital run by Cygnet Surrey Limited. The hospital offers a range of mental health services for men and women across four wards. The service has a sister hospital close by, Cygnet Lodge Woking, which provides a high dependency inpatient rehabilitation service for men and extends the care pathway and a male acute ward for working age adults which opened in July 2021.

Cygnet Lodge Woking is inspected and rated as a separate location.

The same leadership team and registered manager oversee both locations. There are three core services at Cygnet Hospital Woking delivered across four wards with a total of 57 beds.

- Oaktree ward – 11 bedded female only forensic inpatient / low secure ward
- Greenacre ward – 17 bedded male only forensic inpatient / low secure ward
- Acorn ward – 10 bedded female only psychiatric intensive care unit
- Picasso ward – 19 bedded female only acute ward for adults of working age

Cygnet Hospital Woking has been inspected 15 times since it was registered with the Care Quality Commission in November 2010. Hospital was last inspected in August 2021 when we carried out a comprehensive inspection of the acute wards for working age adults and psychiatric intensive care units. The service was rated good overall and requires improvement for effective. Following that inspection, we told the provider it must:

- Ensure there is clear information provided to patients about their rights if they are informal or detained under the MHA. Staff must also be provided with training, so they understand their key responsibilities. This must be reflected in the ward's documentation and patient handbooks. Safeguarding service users from abuse and improper treatment, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 (5)
- Ensure it undertakes serious incident reviews in a timely manner in line with the providers policy and in line with nationally recognised best practice to ensure it can act immediately on any learning and improvements needed to ensure the safety of the patients and staff. Safe care and treatment, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (1) (a)(b)

On this inspection we saw that although the provider had addressed concerns raised following on the last inspection, there were new concerns that needed to be addressed including poor medicines storage, lack of post rapid tranquilisation physical health monitoring on Acute wards and patients were not being given copies of their care plans.

The forensic low secure wards at Cygnet Hospital Woking were last inspected as part of a previous comprehensive inspection carried out in December 2019. This core service was rated good overall, with safe rated as requires improvement. We told the provider it must:

- Ensure that medicines are labelled for individual patients as per providers own policy. (Regulation 12 Safe Care and Treatment)
- Ensure physical observations were being recorded post rapid tranquilisation (RT) administration. (Regulation 12 Safe Care and Treatment)

1.

Summary of this inspection

On this inspection we found that the provider had made improvements to most of the concerns raised previously however, we found an example where physical observations were still not being completed and documented post rapid tranquilisation.

We inspected and rated all core services at this location on this inspection.

Cygnet Hospital Woking is registered to provide the following regulated activities:

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

There is a registered manager who has been in post since October 2021.

What people who use the service say

Acute wards for working age adults and psychiatric intensive care units

Feedback from patients and their carers was positive. Patients felt staff kept them safe. Patients told us that staff involved them in their care, and also explored with them ways to improve the service. They felt overall staff were caring, compassionate and friendly. Staff appeared generally happy, and this reflected in the way they cared for people. Staff were passionate about looking after people and they wanted to do a good job. Some patients reported that compared to other services they had been to, this was a much better service.

However, patients reported that the service could do with more staff. Some patients also reported that the way some members of staff communicated with patients could be better. For example, on Acorn ward patients reported that when they knocked on the nursing window, they were often told to wait which can be frustrating. Patients on Picasso reported that there were sometimes delays in getting their prescribed medication due to the wards being split on two levels.

Patients also felt that staff could check in properly with them more regularly about how they were feeling. They felt they should get more regular one to one time with their named nurse. One carer reported that staff could do more to encourage patients to go out for fresh air.

Patients reported that although section 17 leave was hardly ever cancelled, there were often significant delays and they sometimes do not get the full allocated time.

Forensic low secure wards

We spoke with seven patients who were using the service across both low secure wards.

Patients told us that the environments were clean, comfortable and relaxed. They told us that they felt safe on the wards and that they were happy with the restrictions in place.

All patients spoke positively of most staff and felt they were friendly and supportive. They told us that there were always good staffing levels on both wards and that activities and leave took place regularly and were not affected by staffing. They told us that staff listened well and addressed individual needs.

Summary of this inspection

Patients enjoyed the activities on the ward during the week, including psychology sessions and the gym. Some patients did feel that there was not a lot of weekend activity apart from the gym.

Some patients had a copy of their care plan and felt involved in their care. However, others were not aware of their care plan and told us that they had not received information about the ward or treatment choices. Some patients told us that they used the advocacy services and found them helpful.

Most patients felt comfortable to complain, although some patients identified the lack of response to issues as a problem and felt that it was not worth raising issues because of this. Some patients raised issues about the food and disturbed sleep due to torches being used.

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited all wards at the hospital, including the seclusion rooms, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 16 patients and five carers or family members of patients who were using the service. Interviews with carers were completed by telephone.
- spoke with the clinical nurse managers, regional operations director, hospital manager and medical director
- spoke with 28 other staff members: including ward managers, consultant psychiatrist, nurses, occupational therapists, healthcare support workers, assistant psychologist, compliance manager, physical health lead, housekeeping staff and social work assistant
- spoke with an independent advocate
- attended the hospital daily flash meeting and observed a multidisciplinary ward round
- Carried out one direct observations of care using the Short Observational Framework for inspection (SOFi). SOFi is an observational tool used to help inspectors observe people's care or treatment looking particularly at staff interactions
- looked at 21 care and treatment records of patients
- carried out a specific check of the medicine management on both wards
- looked at four staff human resource files and

Summary of this inspection

- Looked at 36 medication charts across all wards
- Reviewed three clinic rooms
- Reviewed observation documents, incident records, and Mental Health Act paperwork and
- Reviewed a range of policies, procedures and other documents relating to the running of the service.

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

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Acute wards for Adults of Working age and Psychiatric Intensive Care Units

- The provider must ensure that action is taken to safeguard medicines supplies when the temperature of medicines storage areas falls outside of the recommended limits. (Regulation 12).
- The provider must ensure that the medical equipment for measuring blood glucose levels is calibrated (Regulation 15)
- The provider must ensure that on Acute wards patient physical observations are recorded post rapid tranquilisation (RT) administration in line with national guidance. (Regulation 12)
- The provider must ensure there are consistent and clear management plans for diabetic patients and patients admitted with low BMI in line with national guidance (Regulation 12).

Forensic inpatient or secure wards

- The provider must ensure that the medical equipment for measuring blood glucose levels is calibrated (Regulation 15).
- The provider must ensure that action is taken to safeguard medicines supplies when the temperature of medicines storage areas falls outside of the recommended limits (Regulation 12)
- The provider must ensure that consistent monitoring is in place to review the effects of patient's medication on their physical health, particularly all patients prescribed Clozapine (Regulation 12)

Action the service SHOULD take to improve:

Acute wards for Adults of Working age and Psychiatric Intensive Care Units

- The provider should ensure that there are sufficient staff on shifts to meet the needs of the patients.
- Staff should ensure they follow the provider's protocol for admissions in relation to infection control and COVID-19. Staff should ensure that patients who are being discharged are communicated to clearly and there is suitable and appropriate accommodation available prior to discharge.
- The provider should ensure that whenever 'as required' (PRN) medicines are administered for the management of agitation and aggression, patients' responses are recorded.

Summary of this inspection

- The provider should review all patients who have been prescribed rapid tranquilisation to ensure that they have a care plan in place detailing the name of the medication and circumstance for which it is to be used and record the patient's response to the medication.
- The provider should ensure that all patients are offered copies of their care plans.
- Managers should ensure that healthcare support workers on Acorn ward receive supervision that meets their needs and is in line with the provider's policy.
- Leaders and ward managers should consider being more visible on the wards and being more responsive when staff raise concerns.
- The provider should consider enhancing staff awareness and understanding of the rights of informal patients, and ensure information is documented correctly.
- The provider should ensure that physical health monitoring is conducted in a private area in order to maintain dignity.
- The provider should consider making the service more accessible for people with limited mobility and wheelchair users.

Forensic inpatient or secure wards

- The provider should ensure that care plans and follow up information for the management of physical health conditions contain all necessary details and information.
- The provider should ensure relatives and carers are involved in their loved one's care where this is appropriate.
- The provider should ensure that all equipment, including medical devices are checked regularly and maintained to ensure they are in good working order, including the medical emergency bag.
- The provider should ensure the accessibility and accuracy of patient records.
- The provider should ensure that it provides consistent and adequate feedback to patients on any concerns or issues raised.
- The provider should consider how it can ensure appropriate privacy and dignity for patients using the seclusion room on Greenacre ward.
- The provider should ensure that care plans include a balance of patient's strengths, as well as areas in which they need to develop skills.

Our findings

Overview of ratings

Our ratings for this location are:

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

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

Requires Improvement

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

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

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. There was a comprehensive annual ligature audit for each ward. The ligature audits described mitigation for the ligature risks including staff observations of the area.

The provider had a compliance team that was responsible for carrying out a monthly security walk around the ward areas to identify any new ligature points. Findings were then communicated to staff via the ward manager.

There was an allocated security nurse at the start of each shift who ensured that security items such as radios, alarms and keys were working effectively and other items such as cutlery which could pose risks were accounted for. Staff ensured all risk items were stored securely. Patient items that could pose a risk were locked securely in a cupboard leading into the wards.

Although there was a ligature map and photos of each ligature point, it was not always immediately clear what location the photos referred to. Staff told us there were plans to make the ligature map and photo album more robust. The teams were developing an electronic ligature map which would be more user friendly and interactive.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Staff could observe patients in all parts of the wards. Apart from patients' bedrooms, there were CCTV cameras on the wards and outside areas that were patient accessible. There were parabolic mirrors which covered blind spots along corridors and the garden.

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

Requires Improvement

The ward complied with guidance and there was no mixed sex accommodation. Picasso and Acorn were female only wards.

Maintenance, cleanliness and infection control

All ward areas were clean, well maintained, well-furnished and fit for purpose. However, ward staff did not always ensure that they followed the admissions protocol to mitigate the risk COVID-19 infection risk.

Patients told us the cleaning team were very good and they kept the environment immaculate. We saw that the wards were cleaned to a very high standard.

Staff made sure cleaning records were up-to-date and waste were disposed of on time.

Staff followed infection control policy on most occasions, including handwashing. Hand hygiene audit was 100% across both wards. Staff were using masks to reduce to the transmission of airborne infection such as COVID-19. However, we saw on Picasso ward one COVID-19 positive patient that was admitted to the ward was not placed in isolation in line with the provider's policy.

There was a clear process for staff to report maintenance issues. Staff reported this using a green slip which was passed to the maintenance team via the reception staff. Although we saw that the maintenance team made efforts to address concerns raised, it was not always clear how maintenance issues were prioritised.

Clinic room and equipment

Clinic rooms and fridge temperatures were not maintained to ensure pharmaceuticals were kept safely within their specified range. However, the clinic room was clean and had a range of equipment to provide care for patients.

The clinic room temperature on Acorn ward ranged from 25.4 to 27°C between March and April 2022. The maximum fridge temperature was consistently above 8°C between 14 March and 11 April 2022. In addition, staff did not consistently check and record the fridge temperatures. When temperatures were outside of acceptable range, staff reset the thermostat but did not escalate concerns that medicines may be compromised.

The clinic room on Acorn ward appeared very clean, reasonably spacious and tidy. There was hand washing sink and an up-to-date British National Formulary (BNF). However, there were no "I am clean" stickers to indicate when equipment was last cleaned. We also saw a cupboard which was sellotaped shut.

We could not visit the clinic room on Picasso ward because there was a COVID-19 positive patient on the ward who was not in isolation.

There was a range of equipment available to provide care for patients, including in medical emergencies. There was an emergency bag which was checked daily and weighing scales which were both kept in the nursing office. There was a blood glucose meter (BM machine) available. However, there were no calibration records available. This meant that blood glucose testing kits were not being calibrated appropriately.

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

Requires Improvement

There was no clinic room upstairs on Picasso ward. Patients we spoke with told us this was not very convenient for them and caused them delays when getting their medication. Although there was an elevator available, only staff could access it. Managers told us there was business case to split the wards in two where the downstairs ward will be a reception ward and upstairs will be a recuperation ward. They teams have got approval to reinstate the previous clinic rooms upstairs and they hope the work will be completed by June 2022.

Sharp bins were available, and they were not overfilled.

Safe staffing

The service had enough registered nurses nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. However, the service was reporting a high vacancy rate for healthcare support workers and patients reported it can be sometimes difficult to access qualified nurses.

Nursing staff

The provider reported that there were sufficient numbers of staff both registered nurses and healthcare support workers (HCSW) on most shifts to provide care for patients. The service had a matrix for calculating safe staffing numbers.

The service was reporting a low vacancy rate for registered nurses. Managers reported that they have successfully recruited international nurses to posts. They have also been successful at recruiting some agency staff to become permanent staff. However, the service was reporting up to 50% vacancy rate for health care support workers (HCSW). Managers informed us there was ongoing recruitment to fill the HCSW posts. The service was using a high number of agency HCSW. The service was also reporting a high turnover, and the teams were constantly training new staff.

Patients reported that the service could do with more staff. On Picasso ward, patients told us that there were often no qualified nurses upstairs unless they were bringing up their medication. Picasso ward was split in two, upstairs and downstairs wards, and there were locked doors that separated them. Patients reported there was usually one member of staff upstairs, and due to the ward being split, there was a lag in communication, which could sometimes lead to frustration. Staff upstairs often had to phone downstairs if patients needed something. They reported that they sometimes needed to wait for up to three hours to get their PRN medication as the medication room was downstairs.

Staff reported that patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. However, patients on Picasso ward were not always able to go out on leave when they needed to unless another member of staff became available. One patient reported they once waited for up to two hours before they could go out on leave and another patient reported they sometimes could get only 15 minutes when they were allowed two hours due to staff being very busy.

Staff on Acorn ward told us the ward was often short one registered nurse, when the planned number was meant to be two registered nurses. This meant the HCSW were given extra responsibilities, while the nurses stayed in the office and delegated all the tasks. The general feedback from staff was that the healthcare support workers were working under a lot of pressure and were feeling burnt out.

All patients we spoke to felt they could approach staff when they had concerns. Patients had a named nurse. Most patients reported they had regular one to one time with their name named nurse. However, some patients felt that they would benefit from more regular and frequent one to one time with their named nurse.

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

Requires Improvement

Medical staff

The service had enough day and night medical cover, and a doctor was available to go to the ward quickly in an emergency. Patients reported that doctors were available when they needed to see them. Patients on Picasso ward told us the new consultant was responsive and easily accessible.

Managers could call locums when they needed additional medical cover.

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

Mandatory training

Most staff had completed and kept up-to-date with their mandatory training.

Picasso and Acorn ward had overall training rates of 91% and 93% respectively. Staff told us that manual handling training had been rescheduled due to a lack of trainers but once this was completed training would be reach the providers target of 95%. Staff did very little manual handling as the patients that were admitted to the wards were patients that could mobilise unaided.

The mandatory training programme was comprehensive and met the needs of patients and staff. The mandatory training included observation and engagement e-learning, awareness of self-ham, basic and intermediate life support and principles of Mental Health Act and Mental Capacity Act and codes of practice, deprivation of liberty safeguard training and restraint training.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

Staff used recognised tools to assess patients' risks. These included the short-term assessment of risk and treatability (START) and the historical clinical risk management 20 (HCR20) which was completed with input from the ward psychologist. Both were appropriate for the patient group being treated on the wards.

We reviewed 11 care records, including risk assessments and risk management plans and corresponding care plans. Risk assessments were detailed and comprehensive. For all but one patient, risk assessments were always updated following a change in risk or after an incident.

Risks information was shared and discussed as part of the wider multidisciplinary team and appropriate action and support taken.

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

Requires Improvement

Management of patient risk

Staff knew about any risks and safeguarding concerns for each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients.

Staff could observe patients in all areas of the wards including when in they were outside in the communal garden. There were CCTV cameras and parabolic mirrors to mitigate against blind spots.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Although some patients reported they were still able to conceal items and bring in restricted items unto the wards. Staff told us each patient was individually risk assessed, and if there were concerns about their risks they will be placed on enhanced observation.

Staff had completed training in basic and intermediate life support and physical intervention. Prevention Management of Violence and Aggression (PMVA) training was mandatory for staff worked with patients. Staff reported that restraint was only used as a last result only after all other attempts of de-escalation fail.

Use of restrictive interventions

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

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

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff told us there has been an increase in the number of restraints due to some patients being very challenging, some of whom have now been discharged. All staff were PMVA trained.

Picasso ward did not have a seclusion room. Staff reported that bedroom seclusion did not occur. All seclusions would have to be authorised by the multi-disciplinary team, and there must be a clinical rationale for this. Staff on Picasso ward reported that any patient who needed seclusion to manage their behaviour will be immediately referred to a PICU.

Staff on Acorn said that seclusion was rarely used that the seclusion room was used as an extra care area, where patients could request to go for a more low-stimulus environment. When used for this purpose, it was not locked so patients could leave freely. Staff played relaxing music through the speakers and change the colour of the lights for a more sensory experience. The seclusion area was also used by the psychology team for mindfulness group.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received and kept up to date with training on how to recognise and report abuse, appropriate for their role.

Although all staff we spoke to knew how to make a safeguarding referral, and who to inform if they had concerns, they reported that the safeguarding process was going through some changes. Presently, ward managers were responsible for raising alerts to the local authority safeguarding. Managers informed us they were working to make the safeguarding referral process more robust, and the plan was to equip staff to be report safeguarding appropriately and lead on safeguarding investigations.

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

Requires Improvement

Staff knew what to report as a safeguarding for example, patient on patient assault, staff on patient assault, neglect and financial and emotional abuse. Staff told us that all patients assault on staff were reported to the police.

The hospital had a safeguarding lead who staff could contact for advice on safeguarding. Each ward also had a safeguarding champion.

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

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

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

Staff access to essential information

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

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

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

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

Records were stored securely. Permanent and regular agency staff had individual log in credentials, which was password protected. Agency staff that were new to the service were given special access to the computer systems.

Staff told us that the new patient records system was more efficient and user friendly. To minimise the risk of duplication of records, The IT team had disabled the copy and paste functionality. However, staff told us that the computer systems could be better. Staff reported and we saw that it was sometimes difficult to get key information such as most up-to-date policies or risk assessments.

Medicines management

While the service used systems and processes to safely prescribe, administer and store medicines, staff did not always ensure that they carried out physical health monitoring for patients who were given rapid tranquilisation.

When intramuscular medicines (IM) for rapid tranquilisation were given, staff did not always complete post dose observations in line with the organisation's medicines policy. Staff had not completed post dose observation on four occasions for three patients who were given IM rapid tranquilisation.

During our inspection we did not find specific IM care plans for three patients. Following the inspection, the provider sent us examples of care plans for patients, however, the care plans did not contain in all cases the name of the medication to be used and the circumstances in which it was to be used and the patient's response to the medication.

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

Requires Improvement

On most occasions, staff completed medicines records accurately and kept them up-to-date. However, we found one medication recording error where staff recorded they had given IM medication, but the ward manager and patient confirmed that the medication had been given orally.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. They ensured that they sought patient consent prior to disposing of any medicines that were not suitable for use.

Staff stored and managed all medicines and prescribing documents safely. Most medicines related documents were stored electronically on password protected systems. We were told that paper copies of Mental Health Act certificates were stored in folders within the nurses' office.

In all but one occasion, staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. When PRN medicines were prescribed, we saw that the reason for use was recorded on the system. Staff told us medicines were during the ward rounds. However, one patient's PRN medication had not been reviewed for two weeks. Patients and carers could access a pharmacist if they wanted to discuss their medicines in more detail.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Prevention Management of Violence and Aggression (PMVA) training was mandatory for all staff who worked with patients. The organisation's medicines policy encouraged the exploration of non-pharmacological interventions before using medicines. When medicines were used for managing violence and aggression, oral medicines were explored first before injections.

When medicines were not given, staff documented to explain why. However, on one occasion there were no records of why a medicine was not administered or the reason for the missed dose.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute of Health and Care Excellence (NICE) guidance. The hospital employed a lead physical health nurse who ensured that patients had the required blood tests and investigations in line with requirements.

Staff used a spreadsheet to keep track of which patients required physical health checks. However, when patients were prescribed both oral and intramuscular medicines for managing agitation, it was not always clear from records if patients were offered oral medicines first in line with the provider's policy.

Staff learned from safety alerts and incidents to improve practice. Staff received patient safety alerts and we saw that they were reviewed and actioned if relevant with support from the pharmacist. All medicines related incidents were reported via the incident management systems. We saw examples of learning from medicines incident which had led to a change in practice to minimise the risk of reoccurrence. For example, following a complaint by patients about the side effects of their medication, staff were now checking vital signs of patients with consent before and after the administration of a new medication.

Staff ordered medicines from the external pharmacy contractor, who dispensed them and delivered them to the hospital by the next working day. If medicines were required out of hours, staff could send prescriptions to a local community pharmacy.

Access to medicines storage areas was appropriately restricted.

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

Requires Improvement

Controlled drugs were stored appropriate and managed well. There was one controlled drug in the controlled drug's cupboard and records were consistent with the controlled drugs register. Controlled drugs stock checks were completed at each shift and signed by two nurses.

Staff had pictures of consenting service users with the prescription charts to assist in identifying them. Staff ensured that the allergy status of patients was clearly documented.

Stock cupboards were generally tidy and not overfilled. All medications were within date. Medicines with limited shelf life date of opening was clearly recorded.

There was a medicines disposal bin in the clinic room.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. They ensured that all incidents and near misses were reported in line with the providers policy.

Managers debriefed and supported staff following a serious incident. Staff reported there was reflective practice with the psychology team monthly following an incident, although this has since stopped due to lack of a lead psychologist.

Managers had access to e-learning on the intranet on how to investigate incidents or concerns. They investigated incidents thoroughly and involved patients and their families in these investigations. For example, following a serious incident, managers were now required to ensure all staff were competent to observe patients appropriately. However, we saw on Acorn ward that members of staff on one to one were attending to other patients which left patients sufficiently observed at times.

Staff received feedback from investigation of incidents, both internal and external to the service. Lessons learned from investigation of incidents were shared via email, discussed in staff meetings, during handover and via weekly newsletter.

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

Staff understood their responsibilities under the duty of candour. They told us it was about being open and transparent and to give patients and families a full explanation if and when things went wrong.

The service had no never events on any wards.

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

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

Requires Improvement

Requires Improvement

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

Assessment of needs and planning of care

While staff developed comprehensive care plans for each patient that met their mental and physical health needs on most occasions, and involved them in planning their care, staff did not ensure all patients had copies of their care plans.

Out of the 11 care records we reviewed only two patients had been given copies of their care plans. All patients we spoke to said staff had not offered them copies of their care plans. One patient told us they had specifically requested copies of their plans for weeks and staff were yet to give them copies of their care plans.

While staff mostly developed care plans that met the physical health needs of patients, we saw that this was not always consistent. For example, a care plan to monitor and manage the weight of a patient identified as having a high BMI was in place but care plans had not been implemented for two patients with a low BMI. In addition, a diabetes care plan for another patient did not state what their usual blood sugar range should be. This meant that there was a risk that staff may not know what actions to take if a blood sugar reading was outside of the required range for the patient.

Staff told us that care plans were always updated following an incident. However, we saw on one occasion that that a patient's care plan had not been updated following a recent incident.

While informal patients' care plans were personalised, holistic and recovery oriented, patients reported that staff could explore more ways to ensure their needs were being met.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Risk assessments were detailed and identified triggers, strengths and protective factors. The multi-disciplinary teams (MDT) reviewed the patients risks weekly during ward rounds. The nurses were responsible for writing up and updating the risk assessments and care plans. The occupational therapists and psychologists also carried out specific risk assessment and care involved patients in developing holistic care plans.

Best practice in treatment and care

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit. Staff provided a range of treatment and care for patients based on national guidance. However, staff did not ensure there were consistently clear plans of how they would manage patients admitted with low BMI in line with best practice recommendations.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes such as HoNOS (Health of the Nation Outcome Scales) which measured the health and social functioning of people with severe mental illness, and HCR-20 (Historical and risk management 20) which assessed patients' risk of violence.

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

Requires Improvement

Staff provided a range of care and treatment suitable for the patients in the service. The assistant psychologist ran three groups weekly including dialectical behavioural therapy (DBT) skills, staying well group (for relapse prevention and keeping well out of hospital) and unusual experience group. There were individual sessions if required. The psychology team were available Monday to Fridays and the activity coordinators were available five days week form Tuesday to Saturday.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, the provider informed us following the inspection that they engaged in the Music 2 empower programme which is a national initiative aimed to harness the power of music therapy and showcased talents of service users.

The provider also informed us they took part in the Smoke Aware Initiative, a least restrictive intervention aimed at reducing tobacco dependency within in-patient services. The service also had a therapy dog that visited the wards once a week offering comfort and affection to people who were dealing with physical and emotional problems.

There were ample of self-help materials available for patients on the ward. The service also participated in smoking cessation initiatives.

Staff identified patients' physical health needs and recorded them in their care plans. Vital sign checks were completed twice daily on both shifts if patients agreed. Staff escalated concerns escalate to practice nurse who reviewed the patients and made appropriate referrals.

Although staff generally delivered care in line with best practice and national guidance, two patients who were admitted to the service with low BMI were not placed on a food and fluid monitoring chart, and we did not see any referral to a dietitian. This was not in line with the National Institute of Health and Care Excellence (NICE).

Staff used technology to support patients.

Staff took part in clinical audits. Managers used results from audits to make improvements and leaders were monitoring actions plans.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They provided an induction for new staff. Managers supported staff with appraisals and opportunities to update and further develop their skills. However, the healthcare support workers on Acorn ward did not receive individualised supervision line with the provider's policy.

The service had a full range of specialists to meet the needs of the patients on the ward. The staff team included doctors, nurses, occupational therapists, psychologists and health care support workers and a physical health nurse.

Managers gave each new member of staff a full induction to the service before they started work. The induction programme was comprehensive. Staff described the induction as a two week process which included e-learning and classroom based training.

As part of their induction and ongoing process, staff were required to read and understand the provider's policies and procedures including protocols for observing patients. Each staff was required to complete an observation competency which was audited with clinical oversight from the senior leadership team.

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

Requires Improvement

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers told us that agency staff training was done by the agency. Staff qualifications and experience checking was done by the corporate provider.

Managers supported staff through yearly constructive appraisal of their work.

Although the registered nurses received regular clinical supervision, healthcare support workers on Acorn ward told us the supervision they received was group supervision at team meetings and this did not meet all their needs. They were not receiving individual line management supervision. They described them as a session where people were told things they have done wrong.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Records of team meeting discussions were available for staff, and they were also discussed during handover.

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

Managers made sure staff received any specialist training for their role. Staff reported that managers were very supportive if they needed to pursue a higher qualification or specialist training.

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

Multi-disciplinary and interagency teamwork

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

The service had multi-disciplinary teams (MDT) which included the full range of disciplines with the necessary training and skills. Staff held regular multidisciplinary meetings to discuss patients care and treatment. The MDT held weekly ward rounds where patients' treatment, rights, and risks were reviewed and updated. The advocates also attended ward rounds.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Following a ward round, the nurses were required to update the patient records and all changes were communicated to other staff during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. Staff reported a good working relationship with other stakeholders including the local authority safeguarding teams and the police.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

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

Requires Improvement

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The hospital had full time Mental Health Act administrators who were always available to offer support to staff.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The mental health advocates were always available to be contacted and regularly attended ward rounds. There were posters around the wards for how patients could contact them. Although some of the posters on the ward of how to contact the advocates were out of date. Patients reported that the advocates were very helpful and supportive.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. All patients we spoke to knew what section they were on and what it meant, and they told us staff had discussed this with them.

Although staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice, patients reported that there were often significant delays of up to three hours when they needed to go on section 17 leave, which was often due to staff being very busy. Managers told us it was often difficult to plan for patients going on leave at the start of shift as the wards could sometimes get very busy.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Staff made sure that the rights and views of patient were taken into consideration before commencing clinical treatment on most occasion. However, one patient reported that the doctors had changed their medication without fully discussing the options with them. Doctors had asked the nursing staff to give the patient leaflets about their new medication and side effects, but this was not done.

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

Informal patients knew that they could leave the ward freely and the service displayed posters to inform them of this. However, some informal patients reported that they were required to fill out a form prior to leaving the ward which could cause delays and were then required to wait at reception before they were let out of the building. We also saw on informal patient records that staff had written on more than one occasion that "patient utilised section 17 leave without any problems". We raised this with the provider following the inspection and we were informed the reason for the forms was for their own safety. The form contained information such as what they were wearing, where they were going and what time they were expected back. The provider was going to carry out further training with staff, to ensure they understood the rights of patients and the need to record information correctly.

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

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

Requires Improvement

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

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005, and staff assessed and recorded capacity clearly for patients who might have impaired mental capacity.

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

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

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

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

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Capacity to consent to treatment was reviewed in ward rounds and updated regularly.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

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

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

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

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

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

Requires Improvement

All patients and carers we spoke to reported that staff were compassionate and kind. Patients felt staff interacted with them in a respectful, understanding and supportive way, and they showed genuine interest in their wellbeing. For example, patients reported whenever staff brought their medication, they always asked how they felt, took time to listen to them and ensured they felt better and safe before leaving. Another patient reported staff were always calm, and despite facing a lot of abuse and physical assault from some patients, they always responded kindly.

Staff gave patients help, emotional support and advice when they needed it. We saw a patient who appeared in low mood on Picasso ward and was alone by themselves. Staff immediately went over to them and asked if they would like one to one time to discuss any concerns, in a kind and compassionate way. We observed staff speaking to patients during a group activity and we saw that staff were respectful, kind and patients were fully engaged.

Patients said staff treated them well and behaved kindly. Patients reported that staff were very helpful compared to some other hospitals they have been. Some patients told us that staff were brilliant and were dedicated to ensuring patients had the best experience while in hospital.

Patients reported that staff reassured them when there were difficult or challenging situations with other patients, and they encouraged them to think positively.

Staff referred to patients by their preferred names.

Staff respected patient's dignity and privacy. Staff always knocked on patients' doors and asked for permission before entering. Some patients told us that staff hardly entered their rooms.

Staff were very clear that abuse of any form was not tolerated. They felt they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Although staff were generally discreet, respectful, and responsive when caring for patients, we saw that staff were carrying out patients' physical health observation in the communal area on Picasso ward. Following the inspection, managers informed us that they have circulated a memo to stop this practice. Henceforth, the quiet area was to be used for physical health monitoring. Managers reported that because there was no clinic room upstairs on Picasso, it was sometimes difficult to carry out physical health check in the clinic room downstairs. Managers told us the clinic room upstairs on Picasso have now been recommissioned and will become available for use in the coming months.

Staff supported patients to understand and manage their own care treatment or condition. Patients reported the psychology groups, and one to one session were very person-centred.

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

Staff understood and respected the individual needs of each patient.

Staff followed policy to keep patient information confidential.

Although the feedback about the care and support from staff were overwhelmingly positive, some patients felt there was room for improvement in the way some staff communicated with patients. For example, staff could check in more regularly with patients who appear upset to find out how they were feeling. Patients felt they could get more regular one to one time with their named nurse.

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

Requires Improvement

Some patients on Acorn ward reported that when they knock on the nursing office window to speak to staff, they sometimes asked them to wait which can be quite frustrating, as they might have something very emotional and or personal, they needed to discuss.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services on admission. There were admission packs available for patients.

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

Patients could give feedback on the service and their treatment and staff supported them to do this. There was a weekly community meeting where patients could give feedback about the service. Managers reported they regularly attended the community meetings so they could get feedback directly and ensure concerns were dealt with appropriately. For example, following a concern raised by patients on Picasso ward that the doors made a loud noise when staff slammed them shut, managers have now put a notice up to remind staff to shut the doors quietly.

Staff involved patients in decisions about the service, when appropriate. For example, following the inspection, the provider informed us that there was an Expert by Experience lead who regularly visited the wards and supported management decisions around the service including overseeing and capturing feedback from patients.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. There was an advocate who visited the wards daily. Staff reported that the also attended community meetings.

Although patients reported that staff involved them in their care, one patient reported that a doctor had changed their medication without fully exploring the options with them. The doctor had requested that the leaflet be printed and given to the patient, but this was not done. They didn't feel the teams were very supportive on this occasion as they were asked to read the side effects online.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Carers and family members we spoke to told us staff were very good at keeping them informed. They reported that staff often invited them to attend community meetings. Patients felt staff were very accommodating and encouraged them to keep in touch with their families and friends. For example, one patient told us that always reminded them to call their sister.

Staff helped families to give feedback on the service. The service carried out annual friends and family satisfaction survey. A survey was being conducted at the time of our inspection and results had not been published.

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

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

Requires Improvement

Although visitors were not allowed unto the wards, there was a family room outside Picasso ward where patients could meet with their visitors. However, one carer reported that staff could do more to encourage patients to go out for fresh air.

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

Good

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

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit.

Bed management

All patients' referrals came through Cygnet's corporate referral system into a folder. Nurses were required to review the referrals and decide within the hour for patients they will accept.

The service had clear criteria for who they would offer a service. Staff told us they do not have to accept every patient, however, there must be a good clinical rationale for this. For example, staff on Picasso ward informed us they will consider factors such as staffing levels, acuity of the wards and patient mix, and whether the patient had limited mobility and required some form of personal care. Although some staff reported on both Acorn and Picasso that some patients were inappropriately placed.

All beds on Picasso ward had been purchased by Surrey and Borders Partnership NHS Foundation trust, which meant that only patients from this NHS trust were admitted unto the wards. The service had no out of area placements. While some beds on Acorn ward had been purchased by Devon Partnership NHS trust, Dorset Healthcare NHS trust and Avon and Wiltshire Mental Health Partnership NHS trust. Staff reported that some of the contract arrangements were causing some difficulties as patients needed to be discharged back to their local area and finding local placements was a challenge.

At the time of our inspection both Acorn and Picasso beds wards were full. Managers told us there were some planned discharges and also patients waiting to be admitted.

Managers and staff worked to make sure they did not discharge patients before they were ready.

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

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

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

Requires Improvement

Discharge and transfers of care

Managers monitored the number of delayed discharges and took action to reduce the delays. Although the service was reporting a number of delayed discharges, managers reported that the reasons for the delays were mainly due to lack of suitable accommodation or appropriate placement for the patients. We saw attempts by the provider to discharge patients that were well enough, but some had been unsuccessful. There were ongoing conversations between the teams, local commissioners, local NHS trust, care coordinators and other stakeholders. The provider reported that sometimes the patient's local mental health teams were quite slow to accept patients which caused further delays.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Managers told us that the home treatment teams were always involved in discharges. However, this can be challenging if the local teams were far away. They also informed mental health crisis teams and the patients GP when a patient was ready for discharge. However, we saw that one patient on Picasso ward was told by staff and it was written in their notes they were being discharged the next day, but the patient had no place to be discharged to. Managers reported that this was due to a miscommunication and that the patient would only be discharge when a suitable accommodation becomes available.

Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. All patients we spoke to reported that the food was very tasteful, nourishing, with good portion sizes, appetising and of very high quality.

Staff encouraged patients to eat healthy food. There were fresh fruits and vegetables, and healthy snacks available throughout the day. Patients could make their own hot drinks and snacks and were not dependent on staff.

Patients on Picasso reported that the wards were generally quite quiet and relaxing. The service had quiet areas and a visitor's room where patients could meet with visitors in private.

Each patient had their own bedroom, which they could personalise. However, patients could only lock their bedroom doors from the inside and not all patients had access to a key.

Patients had a secure place to store personal possessions. Patients' possessions were kept in a basket in the office. Some items that were used daily were kept in the nursing office. Patients also had safe storage cupboards in their bedrooms.

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

Patients could make phone calls in private whilst they used ward phones. Patients were also allowed their mobile phones.

The service had an outside space that patients could access easily.

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

Requires Improvement

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. Staff told us there were work opportunities for patients in the hospital kitchen. The hospital also offered a vocational rehabilitation programme which involved patients working at the hospital tuck shop, sitting on the interview panels for prospectus staff and they were in the process of looking to place two patients into paid gardening roles. Staff had previously supported some patients to work out at the local supermarket.

Staff helped patients to stay in contact with families and carers. Patients could speak to their family using their own mobile phones or ward phones. If required, staff facilitated virtual video calls.

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

Meeting the needs of all people who use the service

The service met the needs of patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support. However, Picasso ward was not wheelchair accessible.

The service could support and make adjustments for people with communication needs. Managers made sure staff and patients could get help from interpreters or signers when needed. The provider also had information in Easy-Read formats which patients could access.

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

The social work assistants helped patients to deal with a range of issues including applying for benefits claims, debt repayment, ward rounds, family meditation and so on.

Patients had access to spiritual, religious and cultural support. There was a multi-faith room which was easily accessible to patients. Some patients reported that staff also encouraged them to access the Buddhist temple which was adjacent the hospital for some reflection.

While some patients reported that the activity sessions were quite meaningful, some felt there was room for improvement. Examples of activities included painting, manicure and pedicure, going out to the gym, cooking, garden walks, weekend karaoke and so on. There was an occupational therapy timetable seven days of the week. Although patients appeared sufficiently engaged, some patients reported it will be useful to include more therapeutic activities.

There were self-help materials on display across the wards. Including self-help for depression, substance misuse, empowering people on how to take control of their live. Staff also encouraged patients to be more active. There was a table tennis and badminton court available for patients.

While Acorn ward could make adjustment for people with limited mobility, Picasso ward did not have the facilities, and staff did not have the training for how to support them. The bathrooms were not accessible for people with some form of disabilities, and the bedrooms were too small to safely accommodate wheelchair users. Staff reported that currently the service did not admit patients with high acuity that may require a hoist or used a wheelchair. Managers reported that there were plans in place to convert the extra care area to a disabled accessible room which will be wheelchair friendly.

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

Requires Improvement

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. There were posters on the nursing office windows of how patients could make a complaint.

Staff understood the policy on complaints and knew how to handle them. Staff informed us that they would normally at first instance try to understand what the patient's concerns were and try to address them. If this could not be resolved informally, staff would support them to make a formal complaint.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. Patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. For example, we saw that the teams were now carrying out pre and post medication vital signs checks for patients who were prescribed a new medication as result of a patient complaining about the side effects of a new medication.

We saw another example of the psychologist supporting patients to contribute towards creating information sheet to teach staff and patients about understanding the impact certain comments could have on people's emotional wellbeing following a complaint.

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

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

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

Good

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

Leadership

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

Leaders were working hard to improve all aspects of the service from ward to board, to make the service safer, more responsive to patient's needs. For example, leaders were empowering the ward managers to carry out their roles more effectively including supporting them to delegate tasks.

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

Requires Improvement

Managers across the wards met every two months to discuss and learn from one another. Staff reported there were development opportunities for them, for example, clinical team leaders were being trained to carry out the responsibilities of ward managers when ward managers or their deputy were unavailable, with support from more experienced managers on other wards.

Leaders were providing training and awareness to all staff on understanding their legal and statutory duties, including enabling ward managers to be able to submit notifications to statutory and regulatory bodies and to respond directly to queries specific to their wards.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a clear vision of how they will provide optimal care for patients in the safest and most efficient way. Staff knew the provider's vision and values and how they applied to their work and teams.

Leaders could describe the strategy of how they will turn it into action which included developing staff and working with patients, families and other stakeholders. Mangers told us they were working to make the wards safer, least restrictive, with consistently good outcomes for patients and to improve the overall patient and staff experience.

Culture

While most staff felt respected, supported and valued, some staff felt leaders were not always very responsive when they raised concerns, and leaders were not very visible on the wards.

Staff spoke very highly about their teams, how well they worked together and supported one another. Staff told us the culture was generally good and leaders were supportive and made reasonable adjustments where necessary.

Although senior leaders operated an open door policy and encouraged staff to speak to them about any concerns they had, some staff told us there were occasions where they had raised concerns but didn't feel listened to and supported. For example, staff reported that Picasso ward being on two floors was challenging for them and there were concerned that there were not always enough staff.

Managers informed us there was a plan in place to split Picasso ward into two wards with the ground floor becoming a reception ward for new admissions and the upper floor becoming a recuperation ward, for patients who had been successfully treated and awaiting discharge.

Senior leaders told us they were encouraging the ward managers to be more visible on the wards. The senior leadership team have made a commitment to be more visible on the wards and to spend more time interacting with patients.

The provider had a corporate freedom to speak up guardian who staff could contact whenever they had a concern via green button on the intranet.

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

Requires Improvement

After inspection the provider informed us that the services had a mental health first aider, who offered people a welcoming space to express themselves and talk. Other initiatives included Trauma Risk Management (TRiM) which involved supporting people who have been through a traumatic experience and also and Sustaining Resilience at Work (StRaW) a peer support programmed aimed to help detect and prevent occupational mental health issues and boost an organisation's psychological resilience.

Governance

Managers and heads of departments had daily meetings called flash meetings at 9.45am to discuss issues such as incidents, safeguarding, COVID-19 update, staffing, information governance breaches in the last 24 hours, and any other outstanding issues and actions from in the previous days or weekends. The flash meetings took place on weekdays, Mondays to Friday.

There was a monthly ward staff meetings which fed into the hospital wide governance meetings. Clinical governance meetings were thorough and well documented and included shared lessons learned from other Cygnet sites. Managers told us that the regional Cygnet support was positive.

Staff participated in local audits. The service had an agreed, planned schedule of clinical and non-clinical audits. This included regular audits on medicines management, seclusion and long-term segregation, infection control and the Mental Health Act. We saw that audit findings were discussed at clinical governance meetings. However, there were issues which the service's regular audit were failing to pick up including post IM physical health monitoring and physical health care planning.

Policies and procedures were regularly reviewed to make sure they were relevant and in line with national guidance. Staff had easy access to all policies and procedures and were kept updated when changes were made.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

The service had a process for managing risks, issues and performance. However, risk issues at ward level could be managed better.

The service had plans for emergencies, for example, adverse weather or COVID-19 outbreak. There was clear business continuity plan in place to ensure the service continues to run in case of emergencies.

The provider maintained a risk register which covered both ward level and hospital wide risks. Staff had access to the risk register and could escalate concerns when required. However, service risks such as high clinic room and fridge temperatures were not on the risk register.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructures, including the telephone systems worked well and helped improve the quality of care. Staff ensured that patients could keep in touch with family and friends who were not able to visit via video conferencing. As a result of COVID-19, the service had made changes to allow people to attend meetings remotely such as ward rounds or tribunals.

Information governance systems included confidentiality of patient records. The provider has a robust governance process around protecting patients and staff confidential information.

Mangers had access to information to support them with their managerial role. This included information on the performance of the service, and patient care. However, managers did not routinely collect and analyse data on bank staff usage and numbers of unfilled shifts. Managers told us staffing levels were discussed in flash meetings and when there was a staffing shortage on one ward, they would normally get a bank or agency staff in or move people from other wards to manage risks.

Staff made notifications to external bodies as needed such as the local authority safeguarding and CQC.

Engagement

Managers engaged actively with patients, staff and local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Patients and their carers had access to up-to-date information about the work of the provider and the services they used for example through the website, posters and directly from staff.

Patients and carers had opportunities of give feedback on the service they received in a manner that reflected their individual needs. The service was in process of completing a patients and family satisfaction survey. The provider had implemented some changes as a result of feedback from the last patient survey. Patients had been significant improvement in the way staff interacted with patients and the provider was taking a less restrictive approach toward care and treatment.

Staff received regular updates about the work of the provider through regular Cygnet's newsletters, emails, social media and updates at the team meetings.

The provider had just concluded the annual staff survey for 2021. The service had developed and implemented an action plan in response to last staff survey in 2021, and was addressing areas such as bullying and harassment, discrimination and bullying by having more diverse interview panel, and having values champions that will drive the change. The provider had also the changed the name Black and Minority Ethnicity (BAME) to Multicultural Network to be more inclusive.

Staff and patients were encouraged to give feedback. People were supported to provide feedback in a way that was best for them. For example, patients could give feedback through weekly community meetings, patient forums, patient council meetings and through their local advocacy service.

Directorate leaders engaged with external stakeholders, such as commissioners and Healthwatch.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

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

Requires Improvement

Staff were given the time and support to consider opportunities for improvement and innovation that would lead to change. They had opportunities to participate in research and leaders encouraged staff to bring forward new ideas of how to improve the services and outcomes for patients. There were incentives and recognition awards to encourage staff to be more innovative.

Staff told us that the ward consultant on Picasso ward had offered to do a training on alcohol and substance misuse so that staff could better understand how to care for patients with an addiction. Ward managers informed us their plans for the near future is to participate in accreditation schemes for acute and PICU services.

Good

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Each ward carried out daily security checks, with one member of staff nominated as the responsible person for these.

At the previous inspection we raised concerns around maintenance systems not being reviewed to ensure environmental issues were identified and repaired promptly. Staff explained that if something was presenting a significant risk of harm, they would phone maintenance directly and it would be raised as urgent and that maintenance were always responsive and timely. Staff told us that repairs always took place depending on the priority level and we did not observe any issues with environmental disrepair during the inspection. The service had a health and safety audit in place which reviewed outstanding actions of concern, however all lower level maintenance issues were managed by the maintenance department. Senior leaders told us that they will be strengthening the process to ensure there is robust of governance oversight of environmental issues.

Staff could observe patients in all parts of the wards. There was CCTV available which covered the communal areas of all wards. There were also convex mirrors in corridors to allow for clear lines of sight around corners.

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

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Both wards had ligature assessments, carried out yearly, and mitigations available on the wards. Ligature cutters were also seen in accessible locations on the wards.

Good

Forensic inpatient or secure wards

Staff had easy access to alarms and patients had easy access to nurse call systems. All staff had keys and personal alarms which were in use on the wards. Managers told us that two people per shift on each ward were allocated as responders to when the alarms signalled. Staff received training and were aware that in the event of the electronic fob failing, they were able to utilise keys to open and lock doors. They were also able to use their personal alarms to signal for any issues.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. We saw housekeeping staff present on the wards. Staff told us that cleaning staff were present seven days a week. We saw cleaning records that were fully completed and up to date.

Staff followed infection control policy, including handwashing. The service monitored infection prevention and control and audited this through quarterly audits and monthly hand hygiene audits.

Seclusion rooms

Both wards had a seclusion room. These rooms allowed clear observation, full CCTV and two-way communication. They had a toilet and a clock. They also had mood lighting and radio systems so that music could be played into the rooms. The service had not used their seclusion rooms for some months and no patients that we spoke with had been secluded in their bedrooms at the time of the inspection.

Clinic room and equipment

Staff did not carry out regular checks on clinic room equipment to ensure they were available and safe for use. We saw on Greenacre ward; staff had not completed weekly checks on the emergency bag consistently between January and March 2022 for up to three weeks. In addition, staff had not completed checks for some equipment such as blood glucose machine since February 2022 on Greenacre ward.

We saw that there were out of date items such as single use masks, syringes and an oxygen mask which was out of its original packaging on Greenacre ward,

Oxygen cylinders were not always stored securely, and blood glucose testing kits were not always being calibrated appropriately. The provider was told about these findings during the inspection, and they took action to rectify this.

However, clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs. They were clean, spacious and equipped with handwashing facilities. Staff had access to equipment for use in medical emergencies. Electrical equipment were portable appliance tested (PAT) and certified to ensure suitability for use in the last year.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. We reviewed staff rotas and saw that all shifts were covered. During the inspection, both wards had the full complement of staff on both wards. Managers told us that these were always booked in advance to ensure shifts were covered.

Good

Forensic inpatient or secure wards

The service had low and reducing vacancy rates. Greenacre had two permanent mental health nurses and one support worker position that were undergoing pre-employment checks. In addition, there was one vacant support worker position. Oaktree had one permanent mental health nurse and three support worker positions undergoing pre-employment checks, and three vacant support worker positions.

Managers reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. The ward manager could adjust staffing levels according to the needs of the patients. Oaktree had an additional 15 "over recruit" vacancies which managers told us was to allow for additional staffing to cover the higher level of observations required for patients on this ward.

The service had low and reducing rates of bank and agency nurses and nursing assistants on Greenacre. Over the past 12 months and out of a total of 6269 shifts, there were a total of 1464 shifts (23%) covered by bank and agency workers on Greenacre. However, on Oaktree there were 4805 shifts (76%) which was largely made up of shifts to cover the observation levels. Managers told us that they limited their use of bank and agency staff and requested staff familiar with the service who had already been inducted. On Oaktree 65% were permanent bank/agency staff and on Greenacre 35% were permanent bank/agency staff. Most shifts where required were filled by permanent staff taking on overtime.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. This would be a ward-based induction carried out by the nurse in charge and security lead.

Managers supported staff who needed time off for ill health. There was one staff member who was on long term sick at the time of the inspection.

We saw evidence that patients had regular one to one sessions with keyworkers. Managers kept a log of this to ensure that this was always taking place weekly.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Managers, staff and patients told us that there was always a good level of staff to facilitate leave and activities and that these were not cancelled.

Staff shared key information to keep patients safe when handing over their care to others. Staff made sure they shared clear information about patients and any changes in their care during daily handover meetings. They discussed any changes to patients' risks, medication and current management, or anything ward based. They also printed out handover sheets for any agency staff to have this information. Although some staff did tell us that if they were not present for team meetings/ handovers they did not have the time to read emails/ minutes.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The ward doctors for the service were available on the wards during the weekday core hours. There was an out of hours on call doctor rota.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. On Oaktree, 91% of staff had completed their mandatory training and on Greenacre, 92% of staff had. The mandatory training programme was comprehensive and met the needs of patients and staff. It included training inputs on Mental Health Act (MHA) and Mental Capacity Act (MCA), supporting autistic people, awareness of self-harm and suicide, ligature risks, incident management, observations and engagement, physiological observations and safeguarding.

Good

Forensic inpatient or secure wards

Managers monitored mandatory training and alerted staff when they needed to update their training. This was recorded via the service's online "Achieve" system and Managers monitored this to ensure staff were keeping up to date.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were carried out using tools including the Short-Term Assessment of Risk and Treatability (START) and Historical Clinical and Risk Management (HCR-20) and these were led by the Psychology teams. Risk assessments were in place for patients on both wards and these were detailed and contained relevant information. We saw evidence that these were reviewed as necessary, whether that be daily, following an incident or at the fortnightly ward rounds.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients. Individual risk assessments were also carried out on patients to manage any risk, for example, these were in place to identify the safety of areas including kitchen access, possession of bedroom keys and access to computers.

Staff followed procedures to minimise risks where they could not easily observe patients. Where required, staff on both wards followed their observation policy to ensure the management of patient risk. We reviewed observation records and saw that these were clear, and that the allocation of staff matched the prescribed observation level. These also described the patients presenting risk, the reasons for the observation level, and the date of the next review. These also included a column for 'signs of life' to assist in identifying consciousness.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. These searches were also carried out by duty doctors, nurses and the persons keyworker.

Use of restrictive interventions

Levels of restrictive interventions were low. The service provided data for the last 12 months on the prone and patient led prone restraints, and overall restraints carried out on both wards. On Greenacre, there had been eight (prone restraints), three of which were patient led. On Oaktree, there had been nine (prone restraints), one of which was patient led. The total restraints for both wards had been 11 restraints on Greenacre and 67 on Oaktree.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. All staff were trained in the Prevention Management of Violence and Aggression (PMVA) although managers and staff told us that the priority was always on staff deescalating situations verbally, making every attempt to avoid using restraint. Therefore, restraint was only used when these failed and when necessary to keep the patient or others safe. Staff understood the Mental Capacity Act definition of restraint and worked within it.

Good

Forensic inpatient or secure wards

The service had blanket restrictions in place on both wards. These included aspects such as internet access, mobile phone access, laundry access and kitchen access all of which were identified as being individually assessed. Patients we spoke with were happy with the restrictions in place. There was evidence that these were reviewed regularly, and that patients input was also included in the review of these restrictions.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. There were two patients on Long Term Segregation at the time of the inspection. We saw evidence of three-month external reviews being carried out by a local NHS trust team, a four-weekly review from a senior professional not involved in care and a full multidisciplinary review weekly. These patients also had allocated time to engage with therapies and with nursing staff psychology and nurse. One patient was being supported to access community leave to visit a bespoke community placement they were due to be discharged to soon.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role and staff were kept up-to-date with their safeguarding training. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that they would inform their hospital safeguarding lead, a social worker, who would report to the local authority. Staff told us that they would also feel able and confident to report directly if required.

Staff access to essential information

Staff had access to clinical information – whether paper-based or electronic- however, this was not always up to date or easily accessible.

The service used a combination of electronic and paper records for patient care plans and risk assessments which were both comprehensive. However, on both wards, patient notes did not always correlate with the electronic records and some of the paper copies were out of date. In addition, physical health folders were not up to date, some of these have not been updated in the last six to twelve months and they were not always easily accessible due to being stored in different places.

Staff told us that the use of both electronic and paper records was a contingency for if they were unable to get onto the electronic system and that there was a process in place to remove paper files. We fed back concerns around the access to information and leaders told us that they had plans to take this forward to ensure the systems are more streamlined and user friendly. All permanent staff had access to the electronic system and all records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. However, these were not always being followed. Staff did not always review the effects of medications on each patient's mental and physical health.

Staff used prescription charts to prescribe medicines and record their administration. An electronic system was used to document patient progress notes. Staff had pictures of consenting service users with the prescription charts to assist in identifying them. When 'as and when required' (PRN) medicines were administered, the reason for use was recorded however, the effect of the dose given was not always recorded. PRN medicines are medicines administered as circumstances require and are not scheduled. When depot injections were administered, we saw records to confirm that injection sites were rotated.

Good

Forensic inpatient or secure wards

At the last inspection, some medicines for individual use were not labelled for individual patients as per providers own policy. At this inspection, it was clear which medicines were for individual patients. Staff ensured that medicines stock was initialled with patient details as per the current medicines procedure. Staff ordered medicines from the external pharmacy contractor, who dispensed them and delivered them to the hospital by the next working day. If medicines were required out of hours, staff could send prescriptions to a local community pharmacy.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff reviewed medicines during the ward round. Doctors facilitated patients and carers to speak to a pharmacist about their medicines if they wished to do so.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines related documents were stored in clinical areas only accessible by staff, or electronically in password protected systems.

Staff followed current national practice to check patients had the correct medicines. Staff reviewed medicines on admission to ensure that they were suitable for use. Staff conducted medicines reconciliation using admission information.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff (including agency nurses) were alerted by email if they were any patient safety alerts including allergies and adverse reactions. We saw evidence that medicine errors were flagged up via the electronic system which ensured that each alert was reviewed, and action was taken if required. The external pharmacist also completed audits on the service's medication management.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Positive behaviour support (PBS) plans were in place which staff used to minimise the use of rapid tranquilisation (RT). Staff offered the use of the low stimuli room and 1:1 support to reduce anxiety. Support workers used PBS plans to redirect and distract patients when they were agitated to reduce the need for RT.

Access to medicines storage areas was appropriately restricted. However, when temperatures of medicines storage areas were outside of the required range, it was not clear if action was taken to safeguard the medicines. We also saw occasions when the fridge temperature on Oaktree ward was not checked.

Staff had access to medicines disposal facilities, however on Oaktree ward, the sharps bin had been in use for more than three months. We also saw that medicines for disposal were awaiting removal for a week. On Greenacre ward, the date of opening was not recorded on the sharps bin.

Most staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence (NICE) guidance. We saw evidence that staff conducted relevant routine physical health monitoring, for example, electrocardiograms and blood tests for people on antipsychotics. The physical health lead was instrumental in ensuring that patients (including those on high dose antipsychotics) had the appropriate checks.

However, when patients were on medicines that required additional monitoring, (for example Clozapine), we did not always see that this monitoring was done consistently. Specifically, stool monitoring charts were not being completed regularly for three patients prescribed Clozapine. Due to the implications and known side-effects of both medications this was raised at the time of the inspection and the physical health lead sent out an email to staff to remind them to carry out these checks.

Good

Forensic inpatient or secure wards

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. All staff spoken to were aware of the incident management system used at the service and all had training on its use. The service provided data on the number of serious incidents in the past six months. For both wards, there had been four incidents per ward. For Greenacre, these had been in relation to security, violence and aggression. For Oaktree, these had been in relation to self-harm or accident to a person.

Staff raised concerns and reported incidents and near misses in line with provider policy. All incidents were recorded on the management system, and this was then reviewed and approved.

Managers debriefed and supported staff after any serious incident. Staff told us psychology and ward doctors facilitated debriefs with staff and patients following incidents.

The hospital held a daily flash meeting which ensured that all incidents that had taken place in the last 24 hours were discussed and reviewed. Staff received feedback from investigation of incidents, both internal and external to the service. This was sent out in a weekly bulletin to staff and attached relevant policies for staff to reference. Staff told us that they received feedback following incidents both through daily handovers and team meetings. Staff met to discuss the feedback and look at improvements that could be made to patient care following learning from these.

There was evidence that changes had been made as a result of feedback. Managers kept a log of lessons learnt recommendations and carried out an audit to ensure these were rolled out into practice. Managers and staff gave examples of recent lessons learnt. One example was an incident which took place in the Greenacre seclusion room, where issues with the environment were identified as leading to the increased risk during an incident which took place. Following this, changes have been made to the physical environment, making it more robust in aim of preventing any future safety or risk issues when this room is used.

Are Forensic inpatient or secure wards effective?

Good

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs and were recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan where relevant.

However, care plans were not always driven by the patients view of what improvement and progress looked like to them. On both wards care plans focused on what was not working but were not always balanced with patient's strengths.

Whilst patients on Greenacre ward told us that they had copies of their care plans and felt involved in their care, a patient on Oaktree ward told us that they were not aware of their care plan.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Patient care plans were comprehensive and included information on patients' preferences, choices, sensory assessments and their goals. Staff regularly reviewed and updated care plans when patients' needs changed. We saw evidence of care plans being made available in easy read and Positive Behaviour Support (PBS) plans were in place for patients with learning disability and autism.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

The service provided several suitable ward-based activities including board games, movie nights, and colouring. On Oaktree they also engaged in pamper sessions and nail varnish painting and on Greenacre they held electronic gaming/ pool table competitions. The service also brought in a hairdresser three times per week for patients and a Buddhist who facilitated a meditation group for patients.

We observed therapeutic activity timetables on the wards which showed activities scheduled during the week. These were run by psychology, occupational therapy and a gym instructor who delivered various sports and exercise activities. On weekends and evenings, the activities scheduled were ward based/ self-directed. Staff told us that activity coordinators were being scheduled for weekend activity and that often patients access leave to go out shopping and to visit families on weekends.

All patients we spoke with told us that they enjoyed the activities on the ward and that there was a good range. Patients also enjoyed use of the gym however some patients did tell us that there was a lack of weekend activity. Staff told us that there was a small allocated budget per patient per month for activities of their choice but that they would like to see increased meaningful activity taking place with patients on the ward.

Staff delivered care in line with best practice and national guidance. Staff identified patients' physical health needs and recorded them in their care plans. However, we saw that care plans for the management of physical health conditions and any necessary follow up information was not always recorded or detailed enough. During this inspection, we pointed this out to staff and action was taken to update the care plans.

Staff made sure patients had access to physical health care, including specialists as required. A GP attended the service every Tuesday. The service had a practice nurse who took lead on physical health, coordinating GP appointments and supporting care plans around physical health needs.

Good

Forensic inpatient or secure wards

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff refer patients to dieticians and nutritionists as required.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, the provider informed us following the inspection that they engaged in the Music 2 empower programme which is a national initiative aimed to harness the power of music therapy and showcased talents of service users.

The provider also informed us they took part in the Smoke Aware Initiative, a least restrictive intervention aimed at reducing tobacco dependency within in-patient services. The service also had a therapy dog that visited the wards once a week offering comfort and affection to people who were dealing with physical and emotional problems.

The service offered a full range of primary health care interventions including health promotions and physical health screening and had a database in place to track and monitor.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The service used National Early Warning Score (NEWS2) monitoring to assess patients' physical health. They also used the Global Assessment of Progress (GAP) which they completed throughout a patient's stay to measure progress and identify deterioration. We saw that their compliance with this was 100%. Psychology also used Health of the Nation Outcome Scales (HoNOS) as a method of measuring the health and social functioning of people with severe mental illness. It is comprised of 12 scales that measured behaviour, impairment, symptoms and social functioning. This was measured at three months, six months and again at discharge to assess treatment outcomes. The occupational therapy teams also used the Model of Occupation Screening Tool (MOHOST) to measure outcomes a minimum of every six months and enabled ratings to show areas where improvement was needed.

Staff used technology to support patients. Each ward had tablets available to access applications to assist patients. This included patients using these to access mindfulness and self-soothing programmes.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The service was developing sensory safety plans to measure incident data. They were also involved with the Quality Network for Forensic Mental Health Services and were expecting a review from this the month of the inspection.

Managers used results from audits to make improvements. The service had a comprehensive audit schedule in place which covered many areas of the service including medication, safeguarding, health and safety, physical health, mental health act and mental capacity act, observation and engagement and Infection, Prevention and Control (IPC). We saw evidence from the clinical audit on physical health, that both wards had identified issues around NEWS2 being repeated every 12 hours for 72 hours following admission and saw evidence that action had been taken from this audit data to ensure that actions were taken to rectify this.

Skilled staff to deliver care

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

Good

Forensic inpatient or secure wards

The service had access to a full range of specialists to meet the needs of the patients on the ward. The service had access to clinical staff including ward doctors, GP's, nurses and support workers, and therapy staff including psychologists, occupational therapists, social workers and activity coordinators. Where additional specialists were required, such as Speech and Language therapists, the service told us that these were accessed externally.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers showed evidence of the background information they received on bank and agency staff, including all pre-employment checks and training, prior to booking them onto shifts.

Managers gave each new member of staff a full induction to the service before they started work. Permanent staff attended a two-week induction of training and ward introduction prior to starting.

Managers supported staff through yearly appraisals of their work. The service provided the data that 85% of staff on Greenacre and 90% of staff on Oaktree had received appraisals.

Managers supported staff through quarterly clinical supervisions of their work. The service provided the data that 100% of staff on Greenacre and 92% of staff on Oaktree had received clinical supervision.

Managers supported staff through monthly managerial supervision of their work. The service provided the data that 100% of staff on Greenacre and 100% of staff on Oaktree had received managerial supervision. This was carried out by either the ward manager or clinical team leaders.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff received team meeting minutes by email although some staff told us that they often did not have the time to read this information.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff told us that they were supported to complete additional training to upskill themselves. Managers told us that they accessed specific management training. Another member of staff was granted two days per month for study to undertake a PhD in Dementia care. Staff were also completing podiatry training. The training record system and regular supervision and appraisals allows managers to identify any learning areas.

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The service carried out fortnightly ward rounds for each patient which were attended by the multidisciplinary team.

Ward teams had effective working relationships with other teams in the organisation. Multidisciplinary teams worked well together to provide care for patients. We saw evidence of multidisciplinary involvement in daily entries on patient notes and staff accessing multidisciplinary teams for support and advice.

Good

Forensic inpatient or secure wards

Ward teams had effective working relationships and liaison with external community teams and organisations. Staff told us that for example, care coordinators were invited to attend ward round meetings.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. An independent advocate visited the wards regularly. There were also posters within the communal areas of the wards with details on how to contact an advocate.

We saw evidence that staff informed all patients of their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission granted to leave the hospital for those detained under the Mental Health Act) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Section 17 leave and extended home leave were discussed at ward rounds, in addition to future plans, if not currently in place. Patients had section 17 care plans in place. Patients told us that they could access section 17 leave and that this was not cancelled due to staff shortages. We observed this taking place during our inspection.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when required for T3. We also saw that T2 forms (patients informed consent to medical treatment) and T3 forms (where a patient refuses or is incapable of understanding and consenting to medical treatment) were completed and reviewed within 2 years.

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

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

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

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

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

Good

Forensic inpatient or secure wards

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Capacity assessments were led by the most appropriate professional from the multidisciplinary team. For example, financial assessments for capacity were led by the social worker. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff audited how they applied the Mental Capacity Act every quarter and identified and acted when they needed to make changes to improve.

Are Forensic inpatient or secure wards caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. We observed that staff understood patients' needs and treated them with respect and dignity. We observed interactions between staff and patients and found them to be warm, helpful and supportive. Patients told us that staff listened to patients and addressed their individual needs and that they felt that staff genuinely cared for their wellbeing.

Staff supported patients to understand and manage their own care treatment or condition. Patients were encouraged to attend ward rounds and to be involved in managing their own care. We saw evidence of some patients managing their own medication where assessed as appropriate. Most patients we spoke with said that they felt involved in their care.

All patients said staff treated them well, were friendly, supportive, and behaved kindly. Patients also reported feeling relaxed and safe on the wards.

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

Staff followed policy to keep patient information confidential.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients received a welcome pack upon admission, and they were introduced to other patients on the ward when appropriate.

Good

Forensic inpatient or secure wards

Staff involved patients and gave them access to their care planning and risk assessments. All patients told us that they attended their ward rounds and felt listened to by staff. Staff told us that patients completed an interest checklist upon admission to determine what a patient wanted. Patients on Greenacre told us that they had copies of their care plans. However, one patient that we spoke with on Oaktree told us that they were not aware of their care plan.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Care plans were seen to be available in easy read for patients who required this.

Patients could give feedback on the service and their treatment and staff supported them to do this. Community meetings were held weekly and gave patients the ability to bring up any concerns and feedback around the service. Staff told us that patients participated in regular 1:1 session with staff and were given the opportunity to make complaints or suggestions which were recorded and shared with the complaints manager or nurse. The service also provided a patient survey and feedback forms.

Following the inspection, the provider informed us that there was an Expert by Experience lead who regularly visited the wards and supported management decisions around the service including overseeing and capturing feedback from patients.

Involvement of families and carers

We spoke with two carers of patients who used this service. They told us that they received regular updates from the doctor on their relative's care. They also told us that staff were always pleasant when carers phoned for information. Staff told us that carers/ relatives could call at any time and speak with them although if patients did not consent to information being shared, they ensured that carers/ relatives received generic information about the ward/ hospital to keep them updated.

The carers we spoke with told us that they had not been invited to ward round meetings, nor had they been involved in the care planning. Staff told us that they did struggle to involve families but that they were working to resolve and improve this contact. They told us that they arranged carer events and that whenever a patient was admitted they sent out information booklets and a Carers UK leaflet. They told us that previously carers would visit on a specific day but that now this happens on an individual basis and that they were able to facilitate visits in the visitors room, multi-faith room and they had a number of spare visiting rooms in the basement.

Staff helped families to give feedback on the service by providing a friends and family questionnaire and survey link. The carers that we spoke with told us that they would feel confident and able to complain if there were any issues.

Are Forensic inpatient or secure wards responsive?

Good

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

Access and discharge

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

Good

Forensic inpatient or secure wards

Bed management

Pre-assessments were completed on patients prior to admission and multidisciplinary teams were able to identify whether they were able to manage and progress the patients on the ward before they are admitted.

At the time of the inspection, Oaktree had a bed occupancy of 66% with seven patients on the ward, and Greenacre had a bed occupancy of 94% with 16 patients on the ward.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. We saw evidence that future plans were discussed at fortnightly ward rounds and that patients had plans in place to move on. Staff told us that they work to engage and progress patients rather than just having them remain at the service. We were aware of one patient who was in Long Term Segregation moving into a bespoke supported community placement.

The service had out-of-area placements. An out-of-area placement is when a patient is placed in a service which is far away from their normal home. Oaktree for example, had five of the seven patients on the ward from areas a considerable distance away from the hospital which could impact the ability for patients to maintain regular visits with relatives.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. Managers and staff gave an example of a patient on Greenacre who was recently moved to a medium secure unit due to the service not being able to safely meet their needs.

Discharge and transfers of care

The service had low numbers of delayed discharges. Managers monitored the number of delayed discharges. On Oaktree there was one patient whose discharge was delayed and on Greenacre there was two patients whose discharge was delayed. Managers told us that these delays were due to suitable community accommodation being made available to enable the person to move on, as well as COVID and funding issues.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We saw evidence of involvement from NHS commissioning and Forensic Outreach Liaison Services (FOLS) in patients discharge. Staff told us that they had positive working relationships with community teams which helped in facilitating discharges.

Staff supported patients when they were referred or transferred between services. Staff and Managers gave an example of a recent patient moving from Greenacre ward to a medium secure service, and how the communication had been swift between themselves and the receiving service which assisted in the transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own en-suite bedroom, which they could personalise. We saw that patients on both wards had personalised their bedrooms with their own belongings and pictures. Whilst patients had storage within their bedrooms, this was not secure. However, staff and patients told us that they were able to safely lock away valued possessions in the staff office.

Good

Forensic inpatient or secure wards

All patients on Greenacre had keys for their bedrooms. On Oaktree, only some patients had their own bedroom keys. This decision was based on individual risk assessments.

Patients had access to en-suite shower facilities and communal bathroom facilities on each ward. Patients reported that these were always clean which was found to be the case on inspection.

Patients were able to use e-cigarettes within their bedrooms and secure outdoor spaces on both wards. Patients were able to purchase these from the hospital. Staff risk assessed individual access to e-cigarette components and kept them safe in the office if necessary.

The service had a full range of rooms and equipment to support treatment and care. On each ward there were rooms for activity and therapies, including communal social, lounge and dining areas, an Activities of Daily Living (ADL) kitchen and computer room, as well as private call areas and quiet rooms. The access to the therapy rooms was always supervised and these remained locked. The service also had a gym which patients could access. Patients had supervised access to laundry facilities and a rota was in place on the wards.

Patients could make phone calls in private. Patients had access to the ward tablets for video calls and had access to mobile phones whilst on the ward. The phones on the ward were not internet enabled and patients were provided with these if they did not have one, however patients were able to access their own smartphones whilst on leave. Staff charged the patients phones within the office.

Greenacre had an outside space that patients could access easily. This was a garden directly accessed from the ward which patients had access to until midnight. However, Oaktree had no direct access to outdoor space. Managers told us that staff supported patients to access this at regular two-hour intervals throughout the day and always ensured that if requested, they took patients out in addition to these intervals. We observed staff taking patients on Oaktree to access outdoor space during the inspection. There were several outdoor spaces that could be accessed.

While the seclusion room on Greenacre ward had not been used for four months, we identified concerns with privacy and dignity in that it could be viewed from the external ward garden. Managers told us that they were putting in place a fence to prevent the ability to see in through the windows.

Patients could make their own hot drinks and snacks when risk assessed as safe to do so. Otherwise, they were supported by staff to access these. Patients who required support told us that the accessibility to kitchen facilities was good. There were soft drinks and snacks available for patients in the communal areas.

The service offered a variety of good quality food. A central kitchen within the hospital provided meals for patients. A menu was sent out at the beginning of the week and patients could choose the meals they wanted from this. In addition, staff assisted patients to do online shopping and access the in-house tuck shop for additional food/ snacks they may want. Some patients spoke highly of the food and choice available.

Patients' engagement with the wider community

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

Good

Forensic inpatient or secure wards

Staff made sure patients had access to opportunities for education and work. Managers told us that patients were being supported to work in the central hospital kitchen. The service also offered a vocational rehabilitation programme which involved patients working at the hospital tuck shop, sitting on the interview panels for prospectus staff and they were in the process of looking to place two patients into paid gardening roles. They previously supported some patients to work out at the local supermarket.

Staff helped patients to stay in contact with families and carers. Staff used ward tablets to facilitate video calls between patients and family and friends. These were locked to kiosk mode so that nothing else could be accessed and calls could be made privately.

Meeting the needs of all people who use the service

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

The service could support and adjust for disabled people and those with communication needs or other specific needs. Both wards had accessibility for disabled people, including specific bathroom facilities and lift access for upper floors. We also saw evidence of easy read versions of care plans to assist those with communication difficulties. Managers told us that they could access interpreter services if required. They operated within the Cygnet policy around equality and diversity, underpinned by the principles of both the Equality Act (2010) and the Human Rights Act (1998).

Staff made sure patients could access information on treatment, local service, their rights and how to complain. There were information boards in the communal areas of both wards which provided information leaflets on many different things including information on certain health conditions, external services, complaints, CQC and advocacy.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Managers and staff told us that they cater for any dietary requirements including vegan, vegetarian and Halal. There was also a patient who was currently being supported to engage in Ramadan fasting.

Patients had access to spiritual, religious and cultural support. Managers and staff told us that patients were supported to maintain their spiritual and cultural needs. The service had a multifaith room which could be accessed by patients. Staff told us that they always upheld respect of patient's cultural and religious needs and shared information about recent Diwali celebrations that they had held. they also had a chaplain who visited the wards and had previously supported patients to go to church services within the community.

Listening to and learning from concerns and complaints

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

Patients told us they knew how to make formal complaints, and staff supported them to do so. However, staff did not ensure that when patients raised concerns, those concerns were addressed appropriately. For example, two patients told us when they raised concerns about torches shining in their bedrooms when they were sleeping, they did not receive a response or feedback to their concerns, and staff had not acted on their concerns.

Good

Forensic inpatient or secure wards

Staff informed us that when patients raised a concern, the concerns and the actions taken were recorded on the "you said, we did" board. However, on inspection we saw that the board was blank. Staff also informed us that there was a patients council where patients could raise a concern. However, there had been no patient council meetings recently. Two carers we spoke with told us that although they would feel comfortable raising complaints, they were not aware of the process in order to do so.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. We reviewed data provided on complaints received in the last three months and saw evidence of investigations taking place as a result. There was one for Greenacre which involved the attitude of staff. This however was not upheld. There had been none recorded for Oaktree.

We observed compliments regarding patients feedback on staff being celebrated and shared in community meeting minutes.

Are Forensic inpatient or secure wards well-led?

Good

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed, were visible in the service and approachable for patients and staff. Staff were complimentary about the approachability of leadership and the support provided by the senior management team. Ward managers were based on the wards which made them accessible to both staff and patients. Staff told us that leaders often visited the wards and would speak to patients. They told us that senior leaders would also assist in supporting with the management of the wards when needed.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. Staff were consistent in telling us that they were passionate about supporting patients throughout their recovery journeys and pathways and that they enjoyed seeing the progress that they made. The staff survey identified that of the 57% of staff who completed this, they felt the positives of their role was mostly their colleagues, the reward of the work they did and the patients that they worked with.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. All staff we spoke with were happy with their jobs and felt that they were being supported to develop professionally, with some giving examples of specialist training and support to further progress in their careers.

They could raise any concerns without fear. Staff were aware of whistleblowing policies and told us that they would feel comfortable raising issues via this process if they did not feel that their concerns were otherwise being listened to or actioned. Although, all staff told us that they would feel comfortable raising issues directly with line management and senior leaders in the first instance.

Good

Forensic inpatient or secure wards

Staff told us that they felt that there were manageable levels of stress within their roles and that the service were respectful of diversity within the staffing teams. No staff were aware of any examples of harassment or bullying. Staff told us that the service provided a mindfulness session every Friday. Managers told us that they alternated shift patterns to improve work/life balance for staff.

After inspection the provider informed us that the services had a mental health first aider, who offered people a welcoming space to express themselves and talk. Other initiatives included Trauma Risk Management (TRiM) which involved supporting people who have been through a traumatic experience, Sustaining Resilience at Work (StRaW) a peer support programmed aimed to help detect and prevent occupational mental health issues and boost an organisation's psychological resilience.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. Staff told us that there were open lines of communication amongst local level teams and senior managers so that risks were shared and managed well. We saw evidence of risk issues being discussed at daily flash meetings and monthly clinical governance meetings. Clinical governance meetings were thorough and well documented and included shared lessons learned from other Cygnet sites.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Information including patient risk, incident learning and service updates were shared with staff through handovers and regular team meetings, although some staff did tell us that they did not always have the ability to access this information if they were not present for team meetings or did not have the time to read emails. Staff were also supported through consistent supervision and appraisals and any identified performance issues could be monitored and address through these processes. There were some issues with the accessibility and accuracy of patient information in paper files.

The service had an overall risk register, which covered high risk areas of the hospital and described mitigations to manage the risks and included medication management, fire safety, COVID19, risk of suicide and risk of violence and aggression to name a few. Serious incidents, safeguarding's and complaints were appropriately logged and investigated. Various audits were also in place at ward level and learning had been taken from these audits to make improvements. The compliance department had a tracker in place which was able to monitor all incidents reported and to monitor the multiple tasks allocated to these.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in national quality improvement activities. The service collected outcome data of patients through various stages of their care and treatment and used this to identify areas of improvement. This included development of sensory safety plans to measure incident data and were also introducing a quality improvement project to investigate AWOL (absent without official leave) incidents, identify any themes or causes and target these with relevant actions.

In addition, they had a scheduled review taking place by the Quality Network for Forensic Mental Health Services. The purpose of this is to review the quality of the service and facilitate best practice through a supportive and peer review process.

Good

Forensic inpatient or secure wards

Engagement

Managers engaged effectively with other local health and social care providers to ensure that patient needs could be planned for and met.

Staff were able to provide feedback. This included a yearly staff survey and staff suggestion boxes within staff areas which provided the opportunity to feedback anonymously.

Patient feedback was captured at the ward community meetings, via patient feedback forms and through regular one to ones with their keyworkers.

Staff helped families to give feedback on the service by providing a friends and family questionnaire and survey link.

Learning, continuous improvement and innovation

“Lessons learnt” feedback was shared with the wider hospital team via a regular weekly bulletin and staff told us that Cygnet also share learning experiences from other hospitals.

The service had implemented two incident management system champions to help improve the quality of incident entries and the reporting processes. These champions train new starters and provide refreshers for all staff once a year.

The occupational therapy department have implemented “grab and go” boxes to enable ward teams to provide activity outside of therapy hours. These include resources that have been carefully selected.

The service had implemented a “KLOES” project (Key Lines of Enquiry) which enabled them to self-assess against the relevant CQC inspection areas and to attach evidence to these to assure themselves and to make necessary improvements where they do not have sufficient evidence that they are meeting these areas.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The provider did not ensure that medical equipment for measuring blood glucose levels was calibrated. Premises and Equipment, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 (1)(d)(e).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider did not ensure on the Acute wards patients physical observation were recorded post rapid tranquilisation (RT) administration in line with national guidance. Safe care and treatment, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (1)(2)(a)(b) • The provider did not ensure that action is taken to safeguard medicines supplies when the temperature of medicines storage areas falls outside of the recommended limits. Safe care and treatment, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (2)(d)(e)(g) • The provider did not ensure that there is consistent and clear management plans for diabetic patients. The provider did not ensure that there were clear management plans for patients admitted with low BMI. Safe care and treatment, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (2)(a)(b). • The provider did not ensure that appropriate monitoring is in place to review the effects of each patient's medication on their physical health,

This section is primarily information for the provider

Requirement notices

particularly patients prescribed clozapine. Safe care and treatment, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (2)(a)(b).

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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