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	Good
Are services safe?	Good
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 provides low secure services for men and women. We did not inspect or re rate these services on this inspection. The previous rating of good remains in place for the low secure services. We will return to inspect these services in the future.

The hospital also provides acute services and psychiatric intensive care services for women. The psychiatric intensive care service 'Acorn Ward' opened in June 2018. The acute service 'Picasso Ward' opened in December 2020. We have not inspected or rated these services prior to this inspection.

However, there has been a Mental Health Act inspection one month prior to this inspection which identified the following issues needing attention:

- more access to advocacy services were needed
- access to occupational therapy and therapeutic activities was needed in the evenings and at weekends
- attention to maintenance was needed across the wards

On this inspection we only inspected the female acute and psychiatric intensive care services for women and rated these services.

We rated this core service as good overall because:

- There was evidence that staff were monitoring patients physical health effectively. The service employed a nurse and a locum doctor who solely focussed on patients' physical health care. The clinical teams supported patients who had challenging and complex physical health issues safely.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- The management team was responsive in developing plans to address the issues raised in the recent MHA review and we could see that the hospital was progressing with those plans and making improvements.
- The teams on the wards included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers planned to ensure staff received the training they needed, supervision and appraisal in line with the providers policy. Staff across the wards worked well together within their multi-disciplinary teams, and with those outside the ward who would have a role in providing aftercare.

However:

- Whilst restrictive practices across the wards were being monitored, we found that this was not carried out in a way that considered each individual patient's needs, instead an overarching approach was being used. Some restrictive practices placed on patients were not being identified and therefore were not being reviewed effectively. The patients risk behaviours on the acute and psychiatric intensive care wards changed frequently as patients were admitted and discharged quite quickly but we found that the hospital only reviewed restrictive practices every 6 months. This meant that restrictive practices remained in place that were not always appropriate for the patient group being cared for at any one time.
- Staff told us that the provider was offering induction and training to support them working in the acute and PICU wards. Whilst some staff felt this was adequate others felt it did not offer them sufficient acute and PICU specific training to enable them to do their job as effectively as they should or would like.

Summary of findings

- Staff knowledge and understanding of the rights of informal patients (those not detained under a section of the Mental Health Act) was unclear. Patients documentation referred to informal patients having "leave" and staff and patients were not clear about the differences between the rights of informal patients and the rights of detained patients. We found that in four informal patients care notes that staff had documented that they were only able to leave the ward with staff escorting them. This meant their ability to leave the ward was dependent on staff availability when they should have been allowed to leave the ward when they wished. We saw one informal patient notes that stated "leave suspended until Monday"; the patient was therefore, in effect, being detained on the ward and did not recognise their right to leave freely if they wished.
- We found that for a serious incident that had occurred on Picasso ward in August 2021 an incident review process had not been investigated within the 40 day time period as defined in the organisations “incident reporting, management policy” or in line with nationally recognised good practice. The serious incident investigation had not been completed at the time of our inspection. Which meant the hospital could not identify and provide assurance that appropriate and immediate action had been taken to safeguard the patients and staff and that learning to mitigate or prevent further similar serious incidents could inform practice so improvements could be immediately made.

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	Good 	We rated this core service as good overall because: • There was evidence that staff were monitoring patients physical health effectively. The service employed a nurse and a locum doctor who solely focussed on patients' physical health care. The clinical teams supported patients who had challenging and complex physical health issues safely. • Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. • The management team was responsive in developing plans to address the issues raised in the recent MHA review and we could see that the hospital was progressing with those plans and making improvements. • The teams on the wards included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers planned to ensure staff received the training they needed, supervision and appraisal in line with the providers policy. Staff across the wards worked well together within their multi-disciplinary teams, and with those outside the ward who would have a role in providing aftercare • Patients were now happy with the activities offered to them by the occupational therapy team. They were positive about the levels of activity in the evenings and at the weekends However: • Whilst restrictive practices across the wards were being monitored, we found that this was not carried out in a way that considered each individual patient's needs, instead an overarching approach was being used. Some restrictive practices placed on patients were not being identified and therefore were not being reviewed effectively. The patients risk behaviours on the acute and psychiatric

Summary of findings

intensive care wards changed frequently as patients were admitted and discharged quite quickly but we found that the hospital only reviewed restrictive practices every 6 months. This meant that restrictive practices remained in place that were not always appropriate for the patient group being cared for at any one time.

- Staff told us that the provider was offering induction and training to support them working in the acute and PICU wards. Whilst some staff felt this was adequate others felt it did not offer them sufficient acute and PICU specific training to enable them to do their job as effectively as they should or would like.
- Staff knowledge and understanding of the rights of informal patients (those not detained under a section of the Mental Health Act) was unclear. Patients documentation referred to informal patients having "leave" and staff and patients were not clear about the differences between the rights of informal patients and the rights of detained patients. We found that in four informal patients care notes that staff had documented that they were only able to leave the ward with staff escorting them. This meant their ability to leave the ward was dependent on staff availability when they should have been allowed to leave the ward when they wished. We saw one informal patient notes that stated "leave suspended until Monday"; the patient was therefore, in effect, being detained on the ward and did not recognise their right to leave freely if they wished.
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Summary of findings

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Summary of findings

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Summary of this inspection

Background to Cygnet Hospital Woking

Cygnet Hospital Woking provides low secure services for men and women and acute and psychiatric intensive care (PICU) services for women. It has 58 beds spread over four wards:

• Greenacre is a low secure ward for men with 18 beds focusing on assessment, treatment and recovery

• Oaktree is a low secure ward with 11 beds focusing on assessment, treatment and recovery

• Acorn is a female psychiatric intensive care ward with 10 beds, focusing on admission, assessment and treatment.

• Picasso is a female acute ward with 19 beds, focusing on admission, assessment and treatment.

The female acute service opened in December 2020 and the PICU service opened in June 2018.

The core services provided at Cygnet Hospital Woking are :

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

The hospital had an interim registered manager in post at the time of inspection.

The hospital was last inspected in December 2019. At this inspection the hospital was rated as good overall with a rating of requires improvement in safe, all other domains were found to be good.

In this inspection we only inspected the acute and PICU wards and found them to be overall good with requires improvement in the effective domain.

What people who use the service say

During this inspection we spoke with five patients across two wards. The patients we spoke with said that staff were friendly and helpful, and that they were treated by staff with dignity and respect.

Informal patients told us they were sometimes unable to leave the ward and if they tried staff told them that they would be sectioned under the MHA.

All patients were happy with the choice and quality of their food.

Patients told us that the wards were adequately cleaned, comfortable and that their rooms gave them a quiet place to relax.

Patients told us they were happy with the activities offered to them by the occupational therapy team and the activity coordinators based on the ward. They were positive about the levels of activity in the evenings and at the weekends.

Summary of this inspection

How we carried out this inspection

The team that inspected the hospital comprised one CQC inspection manager, one Mental Health Act reviewer, one head of hospital inspection, two CQC inspectors, one specialist advisor and one expert by experience.

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

During the inspection, we looked at the quality of both the ward environments, observed how staff were caring for patients and spoke with patients who used the hospital.

We looked at electronic and paper copies of care and treatment records of patients and reviewed a range of documents relating to the running of the hospital. We also looked at the medicines management on both wards including medicine charts and associated Mental Health Act 1983 documentation and physical health monitoring following administration of rapid tranquilisation.

We observed community meetings and handovers. We also spoke to the hospital's senior managers, ward managers, doctors and other staff members, including members of the multidisciplinary team, nurses and health care assistants.

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 provider MUST take is necessary to comply with its legal obligations.

Action the hospital MUST take to improve:

- The provider 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)**

- The provider must ensure it undertakes serious incident reviews in a timely manner inline 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)**

Action a provider 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 hospitals.

Action the hospital SHOULD take to improve:

Summary of this inspection

The provider should undertake a more frequent audit and review of its restrictive practices across the wards to ensure they are suitable to meet the needs of the patient group

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	Good	Requires Improvement	Good	Good	Good	Good
Overall	Good	Requires Improvement	Good	Good	Good	Good

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

Good

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

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

Good

- The service used locum agency staff who were familiar with the wards and knew the patients well, to fill vacancies. The two wards had a total of three registered mental health nurse (RMN) vacancies out of an establishment of 24 registered nurses and 22 support worker vacancies out of an establishment of 50. Managers told us that ongoing recruitment was happening in order to fill these vacancies. The vacancies were also recorded on the hospital risk register. The ward manager could adjust staffing levels according to the needs of the patients. When we reviewed the staffing vacancies, we could see that the organisation had made significant effort to recruit nurses from overseas and were supporting their transition into the organisation, this was the reason that RMN vacancies were low. We saw evidence of local recruitment days begin undertaken that were designed to attract support workers and that the organisation had a comprehensive package designed to retain staff.
- Managers limited their use of bank and agency staff and used locum agency staff familiar with the wards. We met with locum staff who were happy with their work and had a full induction to the ward when they started.
- Managers made sure all bank and agency staff had a full ward based induction and understood the service before starting their shift. Forms were completed and held on the wards to indicate this was happening so managers were able to track when agency staff were inducted on to the wards
- The service had enough staff on each shift to carry out any physical interventions safely. Each ward had designated response staff who took the lead in a situation requiring physical intervention and were able to attend other wards when required. This meant staff were aware who was attending and ensured safe staffing levels were maintained on all wards.

Medical staff

- Staff told us that there was sufficient medical staff employed, with each ward having its own consultant and associate doctor with a physical health doctor supporting across both wards. This meant the service had enough daytime and night-time medical cover and a doctor available to go to the wards quickly in an emergency.

Mandatory training

- Staff had completed and kept up-to-date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training. All training figures were above 85% (the hospital target for training) and in line with Cygnet organisational training policy.

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

Good

- The provider told us that when The female acute service opened in December 2020 and the PICU service opened in June 2018 the initial staff teams received specific training in the differences between low secure and acute wards to enable them to work on the acute wards. However, staff knowledge of the implementation of the Mental Health Act was not always evident in relation to the management of informal patients. Staff were confused about when and why they would use the sections of the act relating to doctors and nurses holding powers and unclear on the rights of informal patients. Therefore, we were not assured that the training offered about the MHA fully prepared staff to understand their responsibilities.
- Managers monitored mandatory training using a dashboard and liaised with the Human Resources and training manager who 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 only after attempts at de-escalation had failed.

Assessment of patient risk

- Staff completed risk assessments for each patient on admission and there was a consistent risk assessment process in place completed by the medical staff. However, the hospital was in the process of implementing a new risk assessment process. We found that nursing staff could not explain the new risk assessment process and were unsure about how it was being implemented.

Management of patient risk

- Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff used a metal detecting wand to check all patients when they returned from leave.

Use of restrictive interventions

- We saw the organisation had a comprehensive six monthly system of auditing restrictive practices across all wards at the hospital. However, this system did not take into account the dynamic nature of the acute patient group and some restrictions were in place on the acute wards that should have been reviewed based on the individual patients on the wards at the time. For example, all patients were required to have their money held on the ward and locked in a safe regardless of their capacity to manage their own finances. All patients were required to be searched on return from leave, including informal patients who had no identified risk around bringing high risk items into the ward environment.
- 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. Training records showed that all staff across both wards had completed training in reducing restrictive practices.

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.

- The lead social worker was trained to the required level three and oversaw the safeguarding referrals however staff knew how to make a safeguarding referral and who to inform if they had concerns.

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

Good

- Staff understood how to protect patients from abuse and the hospital worked well with other agencies to do so. Staff had face to face training in safeguarding adults and children in their induction and then used e-learning modules to ensure they were up to date. Ninety four per cent of staff on Acorn and all staff on Picasso were up to date with safeguarding training level one. This meant that staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.
- Staff followed clear procedures to keep children visiting the ward safe. There were dedicated visiting rooms in the reception area to the hospital designated for visits and the staff encouraged patients to go out with their family members as much as possible.

Staff access to essential information

Staff had access to clinical information in a format easily accessed by all staff.

- Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. Medical staff used the electronic system and ward based staff typed notes onto the system but also printed out care plans and kept them on the wards. The ward staff were aware of which documents were the latest and we were told the hospital is moving to a complete electronic notes system.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

- We reviewed 25 sets of patients' medicines records and saw that staff followed the correct procedure and practices for prescribing and administering medicine. Each ward had a clinic room that had the equipment that you would expect for this type of service. This included examination couches and electrocardiogram machines (ECG)
- The hospital used an external pharmacy company to audit and advise the clinicians and the clinical governance team on the safe management of medication. Any interventions advised by the pharmacist were communicated with the nursing staff and the prescriber both in written and electronic format. The pharmacist visited the hospital weekly and checked that staff had acted on advice given and fed back to the senior management team.
- Room temperatures and fridge temperatures were recorded and audited regularly. The clinic rooms all had labelled containers for the safe disposal of medications which was signed for securely by two nurses. The management of controlled drugs was safe and in line with national guidance.
- The hospital employed a physical health care nurse who ensured staff knew about safety alerts and incidents, so patients received their medicines safely.
- Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence (NICE)

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. However serious Incident reviews were not always carried out within the timeframes set by the organisational policies.

- Staff reported serious incidents using the electronic incident forms.
- We found that for a serious incident that had occurred on Picasso ward in August 2021 an incident review process had not been investigated within the 40 day time period as defined in the organisations "incident reporting, management policy" or in line with nationally recognised good practice. The serious incident investigation had not been completed

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

Good

at the time of our inspection. Which meant the hospital could not identify and provide assurance that appropriate and immediate action had been taken to safeguard the patients and staff and that learning to mitigate or prevent further similar serious incidents could inform practice so improvements could be immediately made. We asked the hospital to complete this and this has now been done.

- However, we saw evidence that managers and members of the senior management team debriefed and supported staff and patients after the serious incident. Patients and staff told us how the management and the clinical team had carried out debriefing sessions for the patients and debriefing and welfare meetings for the staff team.
- Ward staff meetings reflected serious incident information from the hospital and across the organisation and showed staff discussion of these events.

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

Requires Improvement

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed standardised multi-disciplinary care plans which were reviewed regularly through multidisciplinary discussion and updated as needed.

- Care plans were in place across the two wards. The mental health care plans reflected patients' assessed needs however they mostly followed a standardised format. However, we found the physical health care plans were comprehensive and individualised to the patient health needs.
- Staff carried out audits of care plans and clinical notes every month for four patients per ward at random and we could see that this formed part of a larger compliance and performance management audit to address and improve records management.
- Patients we spoke to told us that they felt involved in their care planning and had been given a copy of the plan after it had been reviewed in the ward round.

Best practice in treatment and care

Staff provided a range of treatment and care for patients. The multi-disciplinary team 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.

- Staff delivered an occupational therapy activity program every day during the day and in the evenings, in line with National Institute for Health and Care Excellence (NICE) guidelines which recommend meaningful and culturally appropriate activities seven days a week and not limited to 9am to 5pm. Most patients felt that there was enough to do, and the activities that were available were suitable to their needs and supported their recovery.
- Patients were able to use the gym in the hospital and staff that were trained to support patients access to the equipment.
- Staff provided a range of care and treatment suitable for the patients in the service. Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The service had access to a full range of specialists to meet the needs of the patients on the ward. We saw risk assessment tools such as the START

(Short Term Assessment of Risk and Treatability) risk assessment being rolled out to add to the Cygnet risk assessment tool. However, staff were not fully familiar with its usage at the time of the inspection. The psychology team told us they were piloting the adapted version of the risk assessment and this would require further training to support its implementation.

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 a ward induction programme for new staff and agency workers.

- Staff identified patients' physical health needs and recorded them in their care plans. The service benefitted from a physical health nurse, and a locum doctor focussing on physical health and we saw evidence of good physical health monitoring. Staff made sure patients had access to external physical health care, including specialists as required, including the dietician. Staff met patients' dietary needs, including any allergies were accounted for.
- Staff from the low secure and rehabilitation wards had been brought over to work on the acute wards when they opened in December 2020. The interim hospital director told us that when the wards first opened, managers implemented a specialist induction programme in order to support staff with the move from the other wards to acute and psychiatric intensive care. Some of the staff felt the training was suitable however some of the staff did not feel that they were being offered sufficient acute and PICU specific training to enable them to do their job as effectively as they should or would like.
- Managers supported medical staff through regular, constructive clinical supervision of their work. Evidence provided by the hospital showed us that supervision sessions were happening regularly, every two months, as per organisational policy.
- Managers recognised poor performance, could identify the reasons and dealt with these with the support of an experienced HR manager who was based on site.

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.

- Staff held twice weekly multidisciplinary ward meetings to discuss patients, improve their care and develop care plans.
- Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Handover meetings followed a clear and structured approach and were minuted and saved onto the shared drive so all disciplines were able to review when they came in on duty. The senior management team also had a "flash" meeting at 09.00 to review any risk or safeguarding activity across the hospital and to check staffing arrangements across the wards.
- Ward teams had effective working relationships with external teams and organisations. The local community was understanding and supportive of patients when they were outside of the hospital. The staff reported good working relationships with the local authority, and the local GP practice who had an agreement to visit the hospital weekly to support and review the patient's physical health care.

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

Staff didn't fully understand their roles and responsibilities for detained patients under the Mental Health Act 1983 and the Mental Health Act Code of Practice. All patients had capacity decisions recorded in relation to

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

Good

their capacity to consent to treatment but we did not find any other capacity related issues being identified or assessed. Managers made sure that staff could explain patients' rights to them. However, informal patient's rights were managed inconsistently and we found the wards were not communicating their rights and documenting their rights effectively.

- Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.
- Informal patients were not aware they could leave the ward freely and were told by staff that if they tried to leave without staff support, they would be sectioned under the MHA. There were no signs on the doors in the downstairs corridor of Picasso ward closest to the exit. We reviewed the patient handbook in relation to informal patients and could see that the handbook had been adapted from the previously existing rehabilitation ward handbook. It referred to not usually supporting informal patients on the ward; 12 out of 18 patients were informal on the day of inspection were informal. The wards were completing section 17 leave forms for informal patients when they wanted to leave the ward and this added to the staff confusion around the status of informal patients. We asked if doctors or nurses holding power had been used if an informal patient was considered too high risk to leave the ward and did not agree to staff supporting them in the community, we were told this had not happened.
- Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who the Mental Health Act administrator was and when to ask them for support. Patients had easy access to information about independent mental health advocacy. 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. There was a form that was completed for informal patients to record that a conversation had happened in relation to their rights however we did not see any of these completed.

Good practice in applying the Mental Capacity Act

Staff supported patients to make some decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity to consent to treatment clearly for patients who might have impaired mental capacity, however we found no evidence of other capacity related decisions being made.

- Staff supported patients to make decisions on their care for themselves. They understood the providers policy on the Mental Capacity Act 2005 and staff recorded capacity clearly for patients who might have impaired mental capacity to consent to treatment. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.
- There was no evidence of capacity being reviewed in any other areas of the patients care, for example, all patient's money was held in the office on the wards and we could not find any recording of whether financial capacity had been assessed to support this decision.

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

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

Good

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 were warm, showed a genuine interest in patients' wellbeing and respected patients' privacy and dignity. Patients told us that staff always knocked on their doors before entering and spoke highly of the staff team.
- Staff used effective de-escalation skills to manage conflict confidently and used their knowledge of the patient group to deescalate violence and aggression before the need for physical intervention. Patients told us that staff were kind and involved their relatives in their care.
- Staff supported patients to understand and manage their own care treatment or condition. Some patients we spoke to felt staff involved them in the care planning process. Most patients told us that they had received copies of their care plans.
- The hospital had recently recruited a pet dog who they had added to the payroll. The pet dog visited the wards on a risk assessed basis and was available to support patients and improve the patient experience.

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

- Patients could give feedback on the service and their treatment and staff supported them to do this. Both wards had regular weekly community meetings and monthly people's council meetings which were attended by representatives from each ward.
- Staff made sure patients could access advocacy services. Advocates visited the wards each week. The advocates would ring the wards weekly to find out if there had been new admissions or discharges and made themselves available.
- The organisation has regular expert by experience inspection and subsequent report, this is when a designated expert by experience visits the site and undertakes an inspection from their perspective of the issues that impact on the patient experience. The senior management team are then responsible in ensuring actions are carried out.

Involvement of families and carers

- Staff supported, informed and involved families or carers. Staff told us that they had regular contact with families and carers. Staff actively sought patient consent to share information with relatives before sharing information. Patients told us that their families and carers were involved in their care. The service used video calling during Covid-19 pandemic restrictions, when visiting was not allowed.

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

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

Good

Staff managed beds well. A bed was available when needed. Staff told us that some patients' discharge was delayed due to non-clinical reasons.

Bed management

- 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. The days we inspected there were patients on community leave and their beds were available for when they returned.

Discharge and transfers of care

- The hospital records that we reviewed showed that there were three delayed discharge patients across both wards. These were related to clinical reasons and the patients had plans in place detailing how to proceed with the support of the commissioning teams.
- The managers regularly reviewed the delayed discharges in clinical governance meetings and had oversight of the patients discharge plans.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity; however, on Picasso ward care was provided over two floors which required staff escort to move between. Each patient had their own bedroom with an ensuite 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 at any time.

- Patients on Picasso had to move between two floors with a staff escort if they wished to leave the building or simply walk between the two floors. This was due to the ward originally being two wards on two floors. Patients had to wait for a staff member to become available to do this and no plans had been reviewed to reduce this restriction. It was unclear why patients could not be individually risk assessed to have their door access fobs programmed to allow them to move between the floors. It was a restrictive practice that had not been reviewed.
- The wards had quiet areas and a room where patients could meet with visitors in private. Patients could meet with visitors in rooms located at the reception of the hospital.
- Patients were risk assessed and able to have their mobile phones while they were on the wards.
- Although the service had outside spaces, patients on Picasso Ward were unable to access it without staff opening the door. This was a restrictive practice but was kept under review dependent on the patient group. Patients on Acorn ward could access the garden area freely throughout the day.
- Patients on each ward had access to a multifaith room.
- Patients could make their own hot drinks whenever they wanted. Patients could ask staff for snacks throughout the day. The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients told us that they were given choices for food and the food was of a good quality and portion size.
- The hospital had recently sponsored the local football team with their kit and as a result the patients were able to access all local home games for free.

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.

- Managers made sure staff and patients could get help from interpreters or signers when needed. Staff told us that they could access translation services when needed.

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

Good

- Patients could make phone calls in private. Patients also had access to their own mobile phones following completion of a risk assessment.

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 knew how to complain or raise concerns. Information was provided to patients in their welcome pack upon arrival. We also saw notice boards on both wards with clearly identified instructions on how to complain and who to complain to within the hospital, to the CQC and the health ombudsman. Staff knew how to handle complaint details sensitively and completed training in how to deal with concerns at work. Staff protected patients who raised concerns or complaints from discrimination and harassment.
- The hospital director shared feedback from complaints and compliments with the ward managers who fed this back to the ward staff via staff meetings, we could see change happening as a result of this process. In addition, the hospital director sent a weekly email to all staff identifying trends in patient complaints for staff to be mindful of.
- Patients received feedback from managers after the investigation into their complaint.

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

- At the beginning of 2020 the hospital director had stood aside to take on a quality assurance role at the hospital. There was currently an interim hospital director in post who had previously been the clinical services manager. The feedback from the majority of staff was that the appointment of the interim hospital director had been positive and they felt she supported the continuous development of the hospital. The hospital was recruiting to fill this post permanently
- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the hospitals they managed and were visible in the hospital and approachable for patients and staff.

Governance

- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that at ward level performance and risks were managed well. However, the hospital had a backlog of incidents that should have been reported to us as per legal requirements. This had built up over the four months preceding the inspection. At the time of the inspection this had been addressed and reports were now being made as required. We agreed not to take any action relating to this but will monitor closely and will take action if the hospital fail to report incidents on time in future.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected and analysed data about outcomes and performance and engaged actively in local and national organisational quality improvement programmes

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

Good

- Managers engaged actively other 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. Managers from the hospital participated actively in the work of the local transforming care partnership.

Vision and strategy

- Staff knew and understood the provider's vision and values and how they were applied to the work of their team. Staff felt they had been included in the development of the new acute and PICU wards and were passionate about their work.

Culture

- The staff we met with felt happy about their work within the hospital and although it felt stressful at times due to the challenging nature of the work posed because patients were acutely ill, they felt supported at work.
- The hospital had made significant steps in their development of staff support systems. Some of these changes were being driven at an organisational level by Cygnet and were being implemented locally. The hospital had implemented two supportive mechanisms, the Trauma Risk Management (TRiM) approach which is a system of supporting staff following traumatic experiences and the Sustaining Resilience at Work approach (StRaW). The hospital had an on sight regional manager in these areas whose responsibility was to ensure staff had access to confidential safe spaces to discuss some of the stresses they felt from inside and outside of the work environment.
- Staff felt that during the COVID pandemic the organisation had taken steps to keep them safe and ensure they had access to the equipment required to enable them to support the patients effectively.

Managing risks, issues and performance

- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- The managers were aware of the top risks on the organisational risk register and communicated them to the ward staff via team meetings when required.
- There was an appropriate clinical governance structure in place to ensure information and risk was escalated and managed in a timely manner. The hospital followed the Cygnet audit schedule and had nominated ward staff responsible for carrying out clinical audits which fed into the governance structure.

Managing information

- Staff had access to sufficient equipment and information technology in order to do their work. The record keeping system was a combination of electronic and paper but was easily available to staff who could update patient care records and to review when needed.
- Ward managers and the lead nurse had systems and dashboards in place to support them in their role. This included information on staffing, supervision and appraisals, training and hospital performance data.

Learning, continuous improvement and innovation

- The acute and psychiatric intensive care wards were focussing particularly on staff support following the COVID-19 pandemic. There were many streams of work being undertaken to make the hospital a safer and more therapeutic environment for staff and patients.
- The acute and PICU wards were working toward their Accreditation for Inpatient Mental Health Service (AIMS)

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding service users from abuse and improper treatment, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 (5). The Hospital did not ensure that informal patients were fully aware of their rights under the Mental Health Act 1982 and that systems and processes on the wards reflected these rights.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (1) (a,b) The hospital did not ensure it carried out serious incident reviews in a timely manner inline with the provider policy and in line with nationally recognised best practice.