Cygnet Behavioural Health Limited

Cygnet Oaks

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Cygnet Oaks is a 35-bed high dependency rehabilitation service for male patients with a primary diagnosis of mental illness.

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

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors to meet the needs of patients. Staff assessed and managed both environmental and individual risks well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed individual care plans for patients informed by a comprehensive assessment of their needs. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward in line with national guidance and best practice. Staff engaged in clinical audit to evaluate the quality of care they provided and made improvements to practice as a result of their findings.
- The ward teams included the full range of specialists required to meet the needs of patients. Managers ensured that these staff usually received regular training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who had a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They involved patients and families and carers in care decisions.
- Staff planned and managed patients' discharge well and liaised well with services that would provide aftercare. As a result, patients rarely experienced a delay to their discharge other than for a clinical reason.
- The service worked to a recognised model of mental health rehabilitation.
- Leaders were experienced and qualified for their roles, they were accessible and approachable to staff. The service had a positive culture where staff felt able to speak up and felt respected and valued.
- Leaders were aware of the risks associated with the running of the service and had taken action to mitigate risks and make improvements.
- People using the service told us that they felt safe, they had access to the rehabilitation support they needed, the wards were usually well staffed and staff treated them with respect.

However:

- Staff had not fully complied with the duty of candour following a notifiable safety incident because the person had not received a written apology.
- The service did not have defined local procedures in place for searching patients on their return from leave. Care plans did not always clearly outline the amount of leave a patient could have that could be facilitated by staff when an escort was needed. Staff did not always record the reason why leave was cancelled.
- Care plans were not always recovery-oriented, some were not up to date with the person's current needs and best interests assessments were not always recorded. Staff did not always record when patients had been given a copy of their care plan. The provider's records audits had not picked up these shortfalls.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Good	

Summary of findings

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Summary of this inspection

Background to Cygnet Oaks

Cygnet Oaks is an independent mental health hospital situated in Barnsley, South Yorkshire. Since May 2018, Cygnet Behavioural Health Limited has been the registered provider of this service. The hospital has previously been owned and operated by other independent providers since it was first registered with CQC on 17 August 2011.

Cygnet Oaks is a 35-bed high dependency rehabilitation service for male patients with a primary diagnosis of mental illness. It accepts both informal patients, who voluntarily consent to stay and receive treatment, and patients detained under the Mental Health Act 1983. The hospital consists of two wards – the Lodge, which is the admissions ward and has 20 beds and the House, which has 15 beds for patients who have progressed on the rehabilitation pathway, including a four bed 'step-through' unit for patients nearing the point of discharge. At the time of our inspection, 34 patients were staying at the hospital. One room was being refurbished as part of an ongoing programme of environmental improvements.

The hospital had a registered manager in position and an accountable controlled drugs officer. Cygnet Oaks is registered to provide the regulated activities: Assessment or medical treatment of persons detained under the Mental Health Act 1983 and Treatment of disease, disorder or injury.

We have inspected Cygnet Oaks eight times previously. The last inspection was a comprehensive inspection carried out in October 2018. At that inspection we rated the service as 'requires improvement' overall. We rated the service as 'requires improvement' under the safe and effective key questions and as 'good' under the caring, responsive and well led key questions. We identified breaches of the following Regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014:

- **Regulation 12 Safe care and treatment:** in relation to how quickly a doctor could attend the hospital in an emergency and concerns about medicines management
- **Regulation 13 Safeguarding service users from abuse and improper treatment:** in relation to prompt intervention following incidents to safeguard people from abuse.
- **Regulation 18 Staffing:** in relation to staff keeping up to date with mandatory training requirements.

We found that the hospital had made improvements in relation to the concerns we identified at our previous inspection and that the regulatory breaches had been resolved.

What people who use the service say

We spoke with seven patients and eight relatives.

Most of the patients we spoke with said they were happy with their care at the hospital. They felt it was promoting their recovery and equipping them with tools to manage their mental health and live more independently when they moved on. They said that staff were respectful and supportive.

Patients told us that they felt safe on the ward and incidents were managed well. Most patients told us the food was good and they were being supported to lead healthier lives. Most patients said that the wards were always well staffed, and the staff were mostly permanent employees rather than agency or bank staff. However, some patients told us that there was not always enough staff to support all their escorted section 17 leave.

Summary of this inspection

Two patients raised specific complaints about their care which were fed back to the manager, who told us that action would be taken to work with the individuals to try and resolve their concerns.

Relatives told us that their family member felt safe at the hospital. They spoke highly of the staff, who they said were respectful and supportive to their family member. Those relatives who had been on the ward said it was clean and senior staff were visible. Some relatives told us they had been involved in reviews of their family member's care and they were invited to meetings, but some said they had not been as involved as they would like. They told us they were able to keep in contact with their family member, using video technology if they did not live close to the hospital. Several relatives told us that they had not been involved in the development of their family member's care plans.

How we carried out this inspection

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

During the inspection visit, the inspection team:

• visited the service and observed how staff were caring for people.

• toured both wards and inspected the clinic rooms.

• spoke with seven patients.

• spoke with eight relatives.

• received feedback from an independent advocate, six commissioning case managers and three care coordinators.

• spoke with nine members of staff including a housekeeper, support workers, nurse, occupational therapists, clinical psychologist and consultant psychiatrist.

• spoke with the registered manager and one of the heads of care.

• observed a ward round, a community meeting and a multi-disciplinary team meeting.

• looked at 15 patients' care and treatment records and 8 prescription cards.

• looked at a range of policies, procedures and other documents relating to the running of the service including meeting minutes, staff files, rotas and handover records.

This inspection was unannounced.

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.

Summary of this 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 SHOULD take to improve:

- The provider should ensure that it always adheres to the requirements of the duty of candour and provides people with a written apology and relevant other information when things have gone wrong.
- The provider should ensure that there are clear policies and procedures in place in relation to searching patients' possessions on return from unescorted leave.
- The provider should ensure that patients have access to clear care plans in relation to their section 17 leave entitlements and that staff record when section 17 leave is cancelled or rearranged and the reason for this.
- The provider should ensure that care plans are recovery-oriented, informed by patients and their relatives/carers (where appropriate) and updated in a timely manner when needs change.
- The provider should ensure that staff consistently document decisions made in patients' best interests, handover information and when patients have been offered a copy of their care plan.
- The provider should ensure that all staff have access to regular supervision and appraisal.

Our findings

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Good

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

Are Long stay or rehabilitation mental health wards for working age adults safe?

Good

Our rating of safe improved. We rated it as good.

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 ward areas and removed or reduced any risks they identified. Ligature risks were assessed using a recognised assessment tool and regularly reviewed at the monthly clinical governance meeting. Fire safety measures were in place and quarterly fire drills were carried out.

Staff could observe patients in all parts of the wards. Where the environment did not allow for clear lines of sight this was mitigated by positioning of staff and individual risk assessments.

The ward complied with guidance and there was no mixed sex accommodation. The service provided accommodation to men only.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Ligature cutters were stored at numerous locations around the hospital and all the staff we asked about them knew where they were, including housekeeping staff.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff told us that, when they used their alarms, there was always a prompt response.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. We did not observe any health and safety hazards or maintenance issues during our tour of the facilities and we saw cleaning taking place. Housekeeping staff told us that they completed deep cleaning on a rota basis in addition to the daily tasks. Patients told us that they were happy with the cleanliness of the hospital and with the furniture provided in their bedrooms.

The cleaning records were displayed in the sluice and were up to date. Cleaning equipment was appropriately stored.

Staff followed infection control policy, including handwashing. Staff were observed wearing Personal Protective Equipment (PPE) appropriately in line with the national guidance in place at the time of the inspection, including face masks to reduce the risk of COVID-19 transmission within the hospital.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment. One of the medicines fridges was out of order during our visit. Medicines requiring cold storage were being appropriately stored in the medicines fridge on the other ward. However, we saw that an out of order fridge did not have a sign to alert staff that it was not working. The service rectified this during the inspection.

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. The manager used a workforce planning tool to ensure there were sufficient staff to meet the needs of the people using the service. Both wards were staffed up to the identified establishment level during our inspection. Staff and patients told us that staffing levels had recently improved at the hospital and the wards were usually fully staffed.

The service had low and reducing vacancy rates. At the time of our inspection the hospital was fully staffed with nurses and had reducing rates of support worker vacancies due to a recent recruitment programme.

The service had low and reducing rates of bank and agency nurses and support workers. Staff and patients told us that there had been a noticeable reduction in the amount of bank or agency staff working at the hospital in the months prior to the inspection. The staffing figures showed that in January and February 2022 there had been no agency nurses working at the hospital and in the four weeks prior to our inspection the rate of agency support workers was not more than 3%. The manager told us that this reduced rate was likely to be sustainable, as it had resulted from the recruitment of additional permanent nurses and support workers.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Written profiles and training logs were obtained for new agency staff members before they started their first shift at the hospital. Bank staff were subject to the same mandatory training requirements as substantive employees.

The service had a turnover rate of 36% in the 12 months prior to our inspection, however staff told us that they felt valued and happy in their roles.

Managers supported staff who needed time off for ill health. Levels of sickness had recently been higher than usual (5.7% in December 2021). The manager told us this was due to the COVID-19 Omicron variant peaking over the months preceding our inspection but the number of staff off sick was now reducing.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients.

Long stay or rehabilitation mental health wards for working age adults

Good

Patients had regular one-to-one sessions with their named nurse. Patients told us that staff had time to talk to them and were approachable.

Staff and patients told us that escorted leave and activities were rarely cancelled due to staffing issues. However, the provider did not have a method for recording when this happened.

The service had enough staff on each shift to carry out any physical interventions safely. The manager told us that the amount of physical space available at the hospital was an asset for staff in managing aggression and preventing situations escalating without the need for physical intervention. Staff and patients confirmed that physical interventions rarely happened.

Staff shared key information to keep patients safe when handing over their care to others. People had clear, comprehensive and up to date records in relation to the risks relating to their care which were accessible to all staff. Patient risks were discussed at handover and in daily morning multi-disciplinary team meetings (Monday to Friday).

We reviewed handover records for the week prior to the inspection. All the records we saw evidenced the sharing of information in order to keep people safe, but some entries were more detailed than others. For example, phrases like 'sleep achieved' were sometimes used, without any additional information about the quality or duration of the patient's sleep. Staff told us that more detailed information was usually shared, but this was not always being recorded.

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. There was a locum consultant psychiatrist, a speciality doctor and a junior doctor working at the hospital. We spoke to the consultant psychiatrist who told us that an on call consultant was available to the hospital 24 hours a day. Nursing and support staff confirmed that they could access a doctor out of hours if they needed to. Patients told us that they were happy with their medical care and they could see a doctor as often as they needed.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Overall, 93% of staff had completed mandatory training at the time of our inspection. The training data was also broken down by staff group and the only group with less than 90% compliance was managers (83%).

The mandatory training programme was comprehensive and met the needs of patients and staff. Staff received training in a range of key areas relevant to their roles including safeguarding, basic and intermediate life support, infection prevention and control, information governance, management and prevention of aggression, equality and diversity and health and safety.

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

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff 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.

Long stay or rehabilitation mental health wards for working age adults

Good

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. All the records we reviewed included comprehensive and up to date information about the risks relating to people's care.

Staff used a recognised risk assessment tool, the short-term assessment of risk and treatability (START). Staff told us they had received training in using this. All the records we reviewed included a completed START tool and evidence that this was being regularly reviewed.

Management of patient risk

Staff knew about any risks relevant to each patient and acted to prevent or reduce risks. Records included a thorough and up to date clinical risk assessment and staff demonstrated an awareness of the specific risks relating to individual patients.

Staff identified and responded to any changes in risks to, or posed by, patients. Information about risk was discussed in ward handovers and multi-disciplinary team meetings daily as standing agenda items, including any changes to identified risks.

Staff followed procedures to minimise risks where they could not easily observe patients. All bedrooms had viewing panels which could be used to aid observations as needed. Areas posing additional risks to patients, such as the ward bathrooms, were locked and patients could access them by requesting a key from staff.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The provider's search policy stated that possessions could be searched on return from unescorted leave as a standard practice. However, the local procedure for searching bags was not clearly defined. The head of care and manager told us that it was not the hospital's policy to always search patients' belongings on return from unescorted leave as a blanket practice, but ward staff and patients told us that bags were always searched on return from leave.

Use of restrictive interventions

Levels of restrictive interventions were low. There were blanket restrictions at the service, and these were discussed with patients at regular People's Council meetings. A blanket rules audit was carried out every six months and the service was up to date with this. Physical interventions were used rarely, in the 12 months prior to our inspection there had been 27 restraints at the hospital involving six patients in total. Two of these were prone (face down) restraints. This type of restraint presents a higher risk of asphyxia for the patient. We reviewed these incidents during the inspection and found that they were handled in line with the Mental Health Act Code of Practice.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The provider's positive and safe delivery board, which was focused on reducing restrictive practice throughout the organisation, met quarterly and minutes of these meetings were shared with staff. Staff received training in safety intervention from a provider accredited by the British Institute of Learning Disabilities (BILD) which complied with Restraint Reduction Network standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Patients told us that restraint rarely happened, and that staff were skilled at verbal de-escalation of conflicts.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff understood the Mental Capacity Act definition of restraint and worked within it. The hospital did not have a seclusion room and we saw no evidence that seclusion had occurred.

Rapid tranquilisation had not been used at the hospital within the 12 months prior to our inspection. Staff told us that it was very rarely necessary to use rapid tranquillisation.

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. All staff had to complete mandatory basic safeguarding training and the safeguarding leads (the head of care for each ward) undertook more advanced training.

Staff kept up to date with their safeguarding training. Ninety seven per cent of staff were up to date with safeguarding training at the time of our inspection.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff told us they challenged discriminatory abuse between peers whenever this was observed on the ward. Most patients told us they felt safe and had not experienced any discrimination. Where patients raised specific concerns about safety or fair treatment within the hospital, these were fed back to the manager and action was taken promptly.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. We saw evidence on patients' records of multi-agency working to promote the safety of the patient and others when patients were working towards discharge.

Staff followed clear procedures to keep children visiting the ward safe. There was a visiting room separate to the main ward area where children could visit their relative safely.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. None of the staff we spoke to had raised any safeguarding concerns recently, but they were able to identify signs of abuse and were familiar with the procedure for reporting safeguarding concerns. We saw from the records of safeguarding referrals that concerns were reported appropriately, including when these arose from incidents between patients. The provider held quarterly regional safeguarding forum meetings and minutes of these were shared with senior staff.

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. The provider had recently introduced an electronic system. Staff had received training on using this and told us that they had no concerns about the record keeping system.

Records were stored securely. Electronic records were password protected and paper records were stored in locked cabinets. Staff managed passwords and keys appropriately in order to keep people's information secure.

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.

Staff followed systems and processes to prescribe and administer medicines safely. We observed a medication round and saw that staff managed medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Patients were supported to self-administer their medicines as part of their rehabilitation where appropriate.

Staff completed medicines records accurately and kept them up to date. We did not identify any errors on the prescription charts we reviewed. The service and an external pharmacist audited prescription charts.

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice. A serious medication error had occurred at the service in September 2021. We saw that action was taken by the provider in relation to staff involved, and that they shared information about the incident more widely with all staff at meetings and through 'lessons learned' bulletins.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each patient's medicines on their physical health in line with national guidance. A registered general nurse offered weekly 'well person' clinics at the hospital for patients to attend for physical health monitoring. Patients prescribed medications with higher risks to their health were in receipt of ongoing monitoring in line with national best practice recommendations.

Track record on safety

The service had a good track record on safety.

There had been one serious incident at the hospital in the 12 months preceding our inspection and we saw evidence that this was thoroughly investigated and information about the lessons learned from the investigation was shared with all staff.

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. Staff told us they had received training in using the electronic incident reporting system and this training also covered what should be reported as an incident.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff reported serious incidents clearly and in line with the hospital's policy. Incident reports were linked to people's care records, and we saw evidence that incidents were discussed in handover and multi-disciplinary team meetings.

The service had no never events and one expected death in the 12 months prior to our inspection.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. However, on one occasion the duty of candour had not been fully complied with following a notifiable safety incident because the person affected had not received a written apology from the organisation about the error, which had a serious impact. We spoke with the patient involved, who had ongoing concerns in relation to the incident. We shared these with the manager and the week following our inspection a letter was sent to the patient apologising on behalf of the organisation and sharing information on the action taken to prevent a similar incident from happening again.

Managers debriefed and supported staff after any serious incident. Staff told us they had been offered a debrief, led by the psychology team, following incidents and they felt well supported.

Managers investigated incidents thoroughly. Patients and their families were usually involved in these investigations. However, some patients told us they were not always offered a debrief following incidents they were involved in.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us that they received email updates about lessons learned from incidents, both within the hospital and from other Cygnet Health Care services. We saw samples of these updates which clearly highlighted the key lessons learned from the incidents and included recommendations to avoid a recurrence of similar issues. Incidents were also discussed at staff meetings and multi-disciplinary team meetings.

There was evidence that changes had been made as a result of feedback. "You Said, We Did" information about changes made in response to feedback was displayed on the wards and included as a standard agenda item at the patients' community meetings.

Are Long stay or rehabilitation mental health wards for working age adults effective?

Good

Our rating of effective improved. 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 usually reflected patients' assessed needs, and were personalised and holistic.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Records showed that each patient's mental health needs were fully assessed at the point of admission and the manager confirmed that they were able to refuse admission of any patient if they were not able to meet their needs within the hospital's model of care.

Long stay or rehabilitation mental health wards for working age adults

Good

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The service had a registered general nurse who maintained oversight of patients' physical healthcare and records showed that patients were receiving care for their identified physical health needs.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Patients had care plans for each of their core assessed needs on the electronic record keeping system. Where patients had additional needs, for example a physical health problem like diabetes, they had a specific care plan in relation to this aspect of their care.

Staff regularly reviewed and updated care plans when patients' needs changed. However, two out of the fifteen sets of records we reviewed included a care plan which did not reflect the individual's current needs.

Care plans were personalised and holistic. However, not all the care plans we saw were recovery oriented. Most contained specific and measurable rehabilitation goals, but four out of the fifteen sets of records we saw included care plans which were written in more negative language and did not include positive goals to be worked towards in collaboration with the individual.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service, which was in line with best practice and national guidance. The service followed provider wide models for rehabilitation which aligned with national best practice guidance. Patients were receiving a range of appropriate psychological therapies.

Staff identified patients' physical health needs and recorded them in their care plans. The records showed that all patients had a physical examination on admission to the service. Individuals' physical healthcare needs were recorded in a dedicated care plan and were kept under regular review.

Staff made sure patients had access to physical health care, including specialists as required. Patients told us that they received the care they needed for specific healthcare problems they had. The records showed that people were supported to access routine physical healthcare appointments such as dental and optical care. The service had a registered general nurse (RGN) who conducted physical investigations such as side effect monitoring for patients taking high-risk medication and in relation to any long-term conditions such as diabetes. The RGN held a weekly drop in 'well person' clinic for patients.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Where patients were assessed as needing support with their dietary needs, they had a care plan relating to this and received support in relation to nutrition and hydration. Menus were displayed which showed the calorific content of each menu option along with a 'traffic light' rating. Menus included healthy options including fruit and vegetables. One patient told us that all the meals came with chips and the menus shared by the provider did show chips, hash browns or roast potatoes to frequently appear as the carbohydrate portion of the evening meal. However, other healthy meal options were available to patients on request.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. There was a well-equipped gym on site which patients could use without supervision following a risk assessment. Most of the patients we spoke to said they enjoyed using the gym and it helped them to feel better. The occupational therapy timetable included activities which promoted health and wellbeing including a walking group, holistic therapy and a 'mindful Mondays' group session run by the psychology team.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Patients' rehabilitation needs were fully assessed by the occupational therapy team using a nationally recognised assessment tool, the Model of Human Occupation Screening Tool (MOHOST), and their progress was monitored by ongoing review against the MOHOST criteria. Nursing staff told us that they used a recognised rating scale to assess neuroleptic medication side effects as needed.

Staff used technology to support patients. We observed a ward round which was attended by the patients' care coordinators, who dialled in remotely using an online conferencing facility. The manager told us that during the 'lockdown' period of the COVID-19 pandemic, patients had access to tablet computers with videoconferencing software in order to maintain social connections and access services outside the hospital.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Discussion of clinical audit findings was a standing agenda item at the monthly clinical governance meetings. Managers used results from audits to make improvements and this was documented on action plans and discussed at team meetings.

Skilled staff to deliver care

The ward teams included the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills, although not all appraisals and supervision meetings were taking place as frequently as they should. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients on the ward. The staff team included a consultant psychiatrist, speciality doctor, junior doctor, clinical psychologist, trainee psychologist, assistant psychologist, occupational therapists, nurses, therapy coordinators, healthcare support workers, chef, cleaners and administrators, including a Mental Health Act administrator and commissioning manager.

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. Staff, including bank staff, received mandatory training and the majority of staff were up to date with this. Staff were supported to work towards additional qualifications. For example, healthcare support workers could access the Cygnet Health Care occupational therapy training pathway and two nursing associates were being funded by Cygnet to complete their nursing qualifications. Staff, including managers, could also access apprenticeships, which were funded by the provider.

Managers gave each new member of staff a full induction to the service before they started work. Staff told us that they had a comprehensive induction, and the staff files we reviewed contained records of this. The manager told us that they provided a longer induction than the basic Cygnet induction programme as the two wards at the hospital were very different and they wanted to ensure new staff were fully oriented to both during their induction period.

Managers supported staff through regular, constructive appraisals of their work. Appraisals were 100% up to date for medical staff, allied health professionals, catering, estates and cleaning staff and managers. Nursing and support worker appraisals were above 75% up to date and all outstanding appraisals were booked in with the relevant line manager to take place soon.

Managers supported medical and non-medical staff through regular, constructive clinical supervision of their work. Over 75% of all staff groups were up to date with their monthly clinical supervision meetings and compliance with this was monitored by the manager.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings were minuted and minutes were circulated to all staff including those unable to attend. Staff were able to join meetings remotely if they were not working a shift that day and were able to claim pay for these additional hours.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff could access the Achieve e-learning portal from home and the manager confirmed staff were paid for their time spent working on training from home. Staff received regular managerial supervision and all staff groups were at least 75% up to date with managerial supervision except for catering staff (63%).

Managers made sure staff received any specialist training for their role. Some staff had recently undertaken ECG and venepuncture training so that they could do more to support patients with their physical health monitoring, which was required due to long term conditions or taking high-risk medication.

Managers recognised poor performance, could identify the reasons and dealt with these. We saw evidence that action was taken in accordance with the hospital's disciplinary policy where there were concerns about staff performance or conduct.

Multi-disciplinary and interagency team work

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. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multi-disciplinary meetings to discuss patients and improve their care. Daily multi-disciplinary meetings took place Monday to Friday at 9am to discuss a range of issues including changes to clinical risk, untoward incidents, changes to observation levels, medication issues and any feedback from patients. These meetings were attended by representatives from nursing, medical, psychology and occupational therapy teams. Support workers did not attend as a matter of course but had opportunities to attend to cover for nursing colleagues. Issues relating to the safe and effective running of the service were also discussed, including staffing and environmental issues. Multi-disciplinary ward rounds also took place weekly, which were attended by the multi-disciplinary team, the patient and external stakeholders.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We reviewed handover records for both wards for the week preceding the inspection which showed that meetings took place at 8am and 8pm when the ward shifts changed. These meetings were structured in a way which would assist staff in identifying and managing risks and changes to patients' needs. However, the quality of record keeping varied in the handover records we reviewed, with some records having a good level of detail but some being briefer. This made it harder to identify how much information was shared at the point of handover in some cases.

Ward teams had effective working relationships with other teams in the organisation. The manager attended regional operational meetings regularly and senior clinicians attended a regional clinical meeting.

Ward teams had effective working relationships with external teams and organisations. Care co-ordinators were involved in people's care, including remote attendance at ward rounds. The manager and safeguarding lead both told us that the hospital had an effective working relationship with Barnsley adult safeguarding team. Most of the care coordinators and commissioning managers we spoke to gave us positive feedback about their working relationship with the hospital.

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. The provider's training compliance data confirmed that 96% of staff were up to date with their Mental Health Act e-learning.

Staff told us that they 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. There was a full time Mental Health Act administrator who was based within the hospital and staff found them to be supportive and accessible.

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.

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. The records we reviewed all contained evidence that patients had been informed about their rights under the Act and patients confirmed they were reminded of their rights regularly.

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. Some patients told us that they were not getting as much section 17 leave as had been agreed. The Mental Health Act records showed that some patients had escorted 'therapeutic leave' authorised for lengthy periods, for example '8am to 8pm daily'. This was to allow patients to leave the hospital with an escort for rehabilitation purposes as required, without additional leave having to be authorised, as their needs fluctuated. However, this practice resulted in some patients gaining the impression that they should be having more time away from the hospital with an escort than it would be logistically possible for staff to facilitate. However, the records did show that all patients who had been granted both escorted and unescorted section 17 leave were utilising this regularly.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

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

There were no informal patients at the time of our inspection. The manager confirmed that when they did have informal patients they could come and go freely from the ward and posters are displayed on the wards and in ward reception areas to remind them of this.

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The outcomes of Mental Health Act audits were discussed at the monthly governance meetings.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The provider's training compliance data confirmed that 99% of staff (and 100% of clinical staff) were up to date with their Mental Capacity Act e-learning.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. No Deprivation of Liberty Safeguard applications had been made in the last 12 months as all patients at the hospital were detained under the Mental Health Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We saw evidence on the records that patients were consulted about all aspects of their care and supported to make decisions.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Where there were concerns about capacity, a more detailed capacity assessment was carried out by the multi-disciplinary team. Capacity and its impact on patient involvement and decision making was considered during the ward round we observed.

When staff assessed patients as lacking capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. However, we found that in three of the five capacity assessments we reviewed, best interests decisions had not been recorded.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications. The manager told us that this was unlikely to ever be necessary as patients were almost always detained under the Mental Health Act.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. Compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards was reviewed and discussed in the monthly governance meetings.

Long stay or rehabilitation mental health wards for working age adults

Good

Are Long stay or rehabilitation mental health wards for working age adults 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 staff speaking to patients with respect and patients told us that they felt staff listened to them. Patients' confidentiality and privacy were respected, for example staff did not go into patients' bedrooms without permission.

Staff gave patients help, emotional support and advice when they needed it. We observed staff assisting patients with daily tasks on the ward. Patients told us that there was always someone to talk to if they needed it. A patient had been supported with end-of-life care and the community team involved in his care praised the hospital's staff for the compassionate and supportive care they offered him prior to his transfer to a hospice.

Staff supported patients to understand and manage their own care, treatment or condition. Some patients told us that they were learning skills at the hospital which they thought would help them to cope better if their mental health deteriorated in the future.

Staff directed patients to other services and supported them to access those services if they needed help. Patients told us how they were receiving support to attend groups outside the hospital, both in person and remotely using technology.

Patients said staff treated them well and behaved kindly. We observed positive and caring interactions between staff and patients during our time on the wards. Most patients told us that staff were always kind and compassionate. One patient said, "it's more than just a job to them". One patient told us they had been spoken to harshly by a member of staff and, when they raised concerns about this, it was not taken seriously. This was fed back to the manager and action was taken immediately to investigate this.

Staff understood and respected the individual needs of each patient. We observed staff treating patients as individuals. Patients told us that there was currently a stable team of permanent staff at the hospital who knew them well.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. All the staff we spoke to said they would feel comfortable raising concerns and they believed action would be taken if they did. One member of staff described how they challenged racial abuse they had observed from one patient to another and how the recipient of the abuse was supported to report this to the police.

Staff followed policy to keep patient information confidential. Records were stored securely, discussions about patients were undertaken in staff only areas and we saw no evidence of inappropriate information sharing.

Long stay or rehabilitation mental health wards for working age adults

Good

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 the admission. Patients received an information pack as part of their orientation process to the hospital. The manager explained that a new patient would also be given a tour of the ward, introduced to peers and staff and given key information, for example about mealtimes, the activity timetable and the time and location of the psychology and occupational therapy drop-in clinics.

Staff involved patients and gave them access to their care planning and risk assessments. Some patients told us they had been offered copies of their care plans and every bedroom had a lockable drawer where records could be securely stored. However, it was not always documented on the records when a patient had been offered a copy of their care plan and declined. Some patients told us they had not been offered copies of their care plans.

Staff made sure patients understood their care and treatment. During the ward round we observed, we saw staff speaking directly to the patient and using accessible language. Patients told us which stage they were at in the hospital's four stage model of care and they understood the implications of this, for example in relation to their progress towards discharge.

Staff involved patients in decisions about the service, when appropriate. We observed a community meeting which was chaired by a patient and facilitated by a member of the therapy team. During the meeting a range of issues relevant to the day to day running of the service were discussed and agreed upon, including group activities and menu choices for communal meals. We saw minutes of previous meetings which showed that these were taking place regularly.

Several of the patients we spoke to complained about a blanket restriction on ordering takeaway food. At the time we inspected takeaways were restricted to Wednesdays and Saturdays only. The manager told us this was to promote healthy eating habits and to support patients with their physical healthcare. Minutes of community and People's Council meetings prior to this restriction being imposed showed that patients were involved in several discussions about this measure and the reasons for it. We saw that this blanket restriction was kept under review at the People's Council, which included patient representation.

Patients could give feedback on the service and their treatment, and staff supported them to do this. Each ward had a patient representative and there were regular community meetings and People's Council meetings at which patients could give verbal feedback.

Staff supported patients to make decisions on their care. We saw evidence in the records and during the ward round we observed patients' views and choices being respected as much as possible.

Staff made sure patients could access advocacy services. An advocate attended the ward twice a week and staff told us that lots of the patients met with them. The contact details for the advocate on the Lodge noticeboard were out of date as the advocate had recently changed, but these were updated on the day of the inspection. The correct contact details were already available for patients at the nursing station, and no one had been prevented from accessing advocacy by this oversight. The most recent reports from the advocacy service showed that patients were engaging with advocacy and that staff worked co-operatively with the advocate to promote patient involvement. We received feedback from the advocate who spoke positively about how staff at the hospital worked with them to promote patient involvement.

Long stay or rehabilitation mental health wards for working age adults

Good

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families and carers. The relatives we spoke to said that they felt the hospital kept them fully informed. Family members told us that during the COVID-19 restrictions they were able to maintain contact with their relative using technology, which was facilitated by the hospital where needed. However, it was not always possible to see how relatives and carers were involved in the development of patients' care plans, including their discharge plans. This is potentially a missed opportunity to harness the knowledge and support available from patients' families to enhance their rehabilitation care.

Staff helped families to give feedback on the service. The hospital regularly wrote to relatives and carers and gave them the opportunity to complete a survey to provide feedback on their views. In the six months prior to our inspection two questionnaires had been returned, both of which contained very positive feedback. The manager told us that they had previously had a carers' group, but this was discontinued during the COVID-19 pandemic. They were now looking at re-starting this due to the relaxation of social distancing restrictions.

Staff gave some carers information on how to find the carer's assessment. Of the seven relatives we spoke to, two had definitely been given the information, one was not sure and four had not been given the information.

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Good

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

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The manager told us that the anticipated average length of stay for a patient at the hospital was 18 months. Of the 34 patients admitted to the hospital at the time of our inspection, nine had been there for longer than 18 months. These patients remained at the hospital due to having ongoing clinical needs which made it appropriate for them to continue to receive inpatient rehabilitation care.

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

When patients went on leave there was always a bed available when they returned. Staff did not move or discharge patients at night or very early in the morning.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interests of the patient. Some of the patients we spoke to in the House ward had moved from the Lodge and they told us they had felt well supported when they moved wards.

Long stay or rehabilitation mental health wards for working age adults

Good

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed and took action to reduce delays to discharge as much as possible.

Patients did not have to stay in hospital when they were well enough to leave. At the time we inspected there were no patients at the hospital who were ready for discharge.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Patients had discharge plans on their records and their progress towards discharge was regularly reviewed. Care coordinators attended the ward round meetings using video conferencing. Most care co-ordinators and commissioning case managers gave positive feedback about how the hospital worked cooperatively with them in planning people's discharge.

Staff supported patients when they were referred or transferred between services. The manager told us that a patient was being supported at the time we inspected with section 17 leave to a community placement that was a potential option for his discharge.

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. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. Patients had a key to their room and could access it throughout the day.

Patients had a secure place to store personal possessions. All rooms included a lockable bedside drawer. Several patients were managing their own medicines and they had secure facilities to store these.

Staff used a full range of rooms and equipment to support treatment and care. The facilities available to patients included occupational therapy kitchens, music and art rooms and a well-equipped gym.

The service had quiet areas and a room where patients could meet with visitors in private. There were relaxation rooms on each ward and several patients told us they used these if they needed time away from the main ward area.

Patients could make phone calls in private. Most patients had their own mobile phones and could access the hospital's WiFi. Where patients were not able to have their own phone due to the risks attached to this there was a portable ward phone which they could use to make phone calls from their bedroom or other private area.

The service had an outside space that patients could access easily. The garden area was locked at midnight during the week and at 1am on Fridays and Saturdays in order to promote healthy sleep patterns. This had been recognised as a blanket restriction on patients and was being regularly reviewed by the People's Council.

Patients could make their own hot drinks and snacks and were not dependent on staff. Patients told us that they were able to make themselves a snack or a drink at any time of the day or night. Some patients had food in their rooms, and some had kitchen space to store food, depending on how much they were choosing to self-cater and their progress along the pathway of care.

The service offered a variety of good quality food. Menus included options for breakfast, lunchtime and evening meals and snacks were available including fresh fruit. Particular diets such as vegetarian and Halal food were catered for. Most of the meal options included a healthy range of nutrients. One of the patients told us that the evening meal included chips every night which was not supporting him to eat healthily, and the menus for the four weeks prior to the inspection did include chips with the evening meal several nights a week.

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. Most patients told us they had been supported to access education and work opportunities in the community and some patients had therapeutic jobs within the hospital for which they were paid. A maths and English tutor attended the hospital during the inspection and the manager confirmed they held weekly classes on site for patients who wished to access them.

Staff helped patients to stay in contact with families and carers. Most patients had their own mobile phones which they could use to have contact with their families and friends during their admission. There was a dedicated room off the ward where patients could meet privately with visitors. Some patients with section 17 leave authorised were using this to make home visits.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. We observed patients interacting with each other on the wards and staff supporting to ensure behavioural expectations were respected. Patients told us how staff were supporting them to access social contacts and support groups in the community.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. One of the wards was on two floors and the lift was in a staff only area. Staff showed us how a patient with mobility needs was being supported to use the lift so they could access both floors. Other than this, all patient-accessible areas of the hospital were accessible to wheelchair users and others with mobility impairments.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Information was displayed on noticeboards on both wards including community opportunities, patients' rights, the complaints and safeguarding processes and the therapies offered at the hospital.

The service had information leaflets available in languages spoken by the patients and in the local community. The information on public display was in English which was the first language of all patients but one.

Managers made sure staff and patients could get help from interpreters or signers when needed. The manager told us that patients whose first language was not English were being supported by interpreters who attended their ward rounds and Care Programme Approach meetings. An interpreter also met with patients as needed to ensure they were able to share their views. Patients were also being supported to communicate with staff using pictoral flash cards when the translator was not present. We received feedback from a commissioning case manager who believed their patient was being well supported in relation to their communication and language needs.

Long stay or rehabilitation mental health wards for working age adults

Good

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients told us that Halal and vegetarian food was available when this was requested.

Patients had access to spiritual, religious and cultural support as requested. There had been an issue around a patient not being able to meet privately with their spiritual advisor, but this had been resolved and an apology offered to the patient affected.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. Patients told us that when they had raised concerns action was usually taken to resolve their issues

The service clearly displayed information in patient areas about how to raise a concern.

Staff understood the policy on complaints and knew how to handle them. Staff told us that complaints were usually about minor issues such as missing laundry and were resolved informally on the ward, however they were aware of the formal complaints process and supported patients to access this when needed.

Managers investigated complaints and identified themes. The registered manager tracked complaints using a spreadsheet to ensure that response timescales were met, and any themes of concern were identified.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Patients said they did not think they had been discriminated against due to making a complaint.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. However, one patient, who told us he had had raised a complaint following a serious incident, had not received a written response due to this being handled as an untoward incident primarily. The manager sent him a written response and apology the week following our inspection.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints and changes made as a result of concerns raised by patients were discussed at staff meetings and multi-disciplinary team meetings.

The service used compliments to learn, celebrate success and improve the quality of care. A log of compliments was kept and information about compliments received was shared at staff meetings.

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Good

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

Long stay or rehabilitation mental health wards for working age adults

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 visible in the service and approachable for patients and staff.

All leaders at the hospital were experienced registered mental health nurse managers with appropriate knowledge, skills and experience to manage a high dependency rehabilitation service.

The hospital manager and heads of care were experienced, and the management team was stable. Staff told us that senior leaders were visible and approachable. Some patients told us that they would like leaders to be more accessible to them. The registered manager prepared a regular newsletter for staff to share information on a range of issues and chaired a regular People's Council meeting at the hospital which involved both staff and patients.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The provider's overarching values were care, respect, trust, empowerment and integrity**.** The staff we spoke to knew what they were and believed that the hospital was providing care to people in line with these values. Staff were able to give examples of how the values were upheld in practice, such as positive risk taking to empower patients and staff acting with integrity by engaging in an open and transparent reporting culture.

Culture

Staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

All the staff we spoke with told us they felt valued by the organisation and they were happy in their role. Staff also told us that they felt confident that they could raise concerns and that action would be taken if they did. Staff believed there was an open reporting culture within the hospital and that the leadership team were receptive to feedback from staff at all levels. Some international nurses had been recruited recently. They were not available for interview during the inspection but other ward-based staff told us that cultural awareness was covered in their equality and diversity training. Staff told us that racism and sexism, including from patients, was always challenged and the manager told us how staff were supported in the event of experiencing discriminatory abuse from patients.

There was a Freedom to Speak Up Guardian at the hospital and staff knew who they were and the process for raising concerns. We saw evidence that concerns had been raised with the Freedom to Speak Up Guardian in the 12 months preceding our inspection and that action had been taken in relation to these. We spoke staff members who had raised a concern and they said it had been resolved to their satisfaction. No formal grievances had been raised by any staff in the 12 months prior to our inspection.

An annual staff survey was carried out at the hospital, most recently in January 2021. The response rate for this was 100% of staff. Staff feedback was mixed, with a majority of positive responses in some areas, such as support from line managers, training provision and staff feeling able to raise concerns safely, and some less positive feedback, for example in relation to terms and conditions and workloads. Staff feedback was discussed at governance meetings and an action plan was put in place to respond to areas of concern highlighted. Staff gave us examples of when action had been taken by managers following their feedback, for example in relation to giving more notice of changes to shift patterns. The provider confirmed that the 2022 survey was out for staff feedback at the time of our inspection.

Long stay or rehabilitation mental health wards for working age adults

Good

Governance

Our findings from the other key questions demonstrated that governance processes usually operated effectively at team level and that performance and risk were managed well.

Quality monitoring processes took place including a range of audits (record keeping, health and safety, infection prevention and control, medication, observations, blanket restrictions and Deprivation of Liberty Safeguards). High level findings from these were reported to and discussed at monthly governance meetings and action was taken to address any issues identified by the audits.

However, there were some areas of the hospital's governance arrangements where audits had not identified the concerns we found during the inspection, for example, concerns with care plans, the documentation of best interests decisions and recording cancelled leave.

The hospital had a clearly defined governance structure which included daily morning meetings taking place Monday to Friday. These were for the multi-disciplinary team to review a range of issues relevant to the running of the hospital as well as any significant changing risks or other issues relating to specific patients.

There were also monthly governance meetings which were chaired by the registered manager and included input from the multi-disciplinary clinical team. At the governance meetings a range of data was reported and discussed including staffing levels, staff training compliance, care plan outcomes, levels of meaningful activity for patients, safeguarding concerns, incidents, patient and carer feedback, regulatory compliance issues and complaints. Information from the hospital's local governance meetings fed into regional operations meetings and regional clinical meetings which were attended by relevant senior staff from the hospital.

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.

All the records we viewed included comprehensive and up to date risk assessments, which informed the patient's care plans. Staff had access to all the information they needed in relation to the patients they worked with through the electronic record keeping system. Individual clinical issues including changes to risks, changed observation levels, incidents and any medication issues were discussed at handover meetings and daily multi-disciplinary team meetings, which were minuted and the minutes were shared with staff who did not attend.

There was an over-arching risk register in place for the service at which key staffing, clinical, environmental and other risks were documented and kept under regular review. The register showed that action was taken to reduce the level of all identified risks as far as possible.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service was not involved with any national improvement activities. However, the service used recognised tools to monitor outcomes and progress and benchmarked against other similar services within the Cygnet Health Care group.

Long stay or rehabilitation mental health wards for working age adults

Good

Engagement

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 service participated actively in the work of the local transforming care partnership.

Patients' care coordinators attended their ward rounds remotely using video conferencing facilities. Ongoing discussions were taking place with social care providers and community mental health teams in planning for patients' discharge, in order to facilitate a smooth transition for people when they left the hospital.

We received feedback from eight commissioning case managers and three care co-ordinators. Most of the external stakeholders told us that they were happy with their patients' progress at the hospital and with the level of information sharing from the hospital.

Learning, continuous improvement and innovation

The provider had recently introduced Quality Improvement (QI) training for staff on the Achieve e-learning platform which all staff could access. The head of care told us that they used a 'Plan, Do, Study, Act' QI approach to implementing changes to ways of working on the wards. The hospital had a QI lead, who was one of the heads of care.

At the time we inspected the hospital was working towards Accreditation for In Patient Mental Health Services (AIMS). This was at an early stage, but they were beginning to gather evidence of how they are meeting the AIMS standards of care.