

Cygnets Alders Clinic

Quality Report

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

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

Summary of findings

Overall summary

This was a focussed inspection. We inspected Cygnet Alders Clinic following concerns raised to us by local GPs and others about the model of care being used at the service. In response to this we took with us two specialist advisors with expertise in working with people with a personality disorder. We have not changed the ratings and the services remains 'good' overall.

We found that:

- Staff worked to ensure patients were kept safe. This was achieved through regular and timely risk assessments and the handover of relevant risk information. The service had good lines of sight, and staffing numbers were adjusted to meet patients' needs. For example, where patients needed enhanced observations extra staff were on shift to do this, and where patients were deemed to be too high risk to visit a GP practice, a registered general nurse was sourced to meet the patients need.
- Where incidents did happen, staff knew how to report these. They demonstrated learning from these events, could explain how learning was shared within the team, and with other services across the provider. Patients said they felt supported and safe when cared for by substantive staff. Permanent staff numbers had increased over the year before this inspection to reduce the need for bank or agency staff.
- Patients had their needs assessed in a holistic way, and staff updated care plans in a timely way. There was a range of recovery focused psychoeducational groups and therapeutic activities. A clinical psychologist had recently been appointed to help improve patients' access to therapies recommended by the National Institute for Health and Care Excellence.
- There was an increasing network of care available to patients, improved by the relationships that staff had with other local services. This included good relationships with safeguarding and local A&E departments. A memorandum of understanding was being drawn up to help strengthen relationships with local GP practices.
- The service had recently been taken over by a new provider organisation and some systems were still being embedded. However, we saw that staff benefitted from present and strong leadership from managers in the service, and that there were systems in place to ensure performance was tracked and improved. Staff could explain how they had made suggestions to improve the service, and these had been implemented. The service was also applying for accreditation with the Royal College of Psychiatrists under it's Accreditation for Inpatient Mental Health Services scheme.

Summary of findings

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Good **Cygnet Alders Clinic****Services we looked at**

Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Cygnet Alders Clinic

Cygnet Alders Clinic (previously known as Alders) is a 20-bedded service for women with complex mental health needs and personality disorder diagnosis. There were 16 patients at the service at the time of this inspection.

There are three distinct care areas within the service that patients pass through on their journey from admission to discharge. These are:

- Severn ward: patients receive on going assessment of their individual needs
- Avon ward: patients receive treatment based on the outcome of their assessments

- Coln ward: patients prepare for discharge

The service is registered to carry out the following regulated activities:

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

There was a registered manager in place at the time of the inspection. The last inspection of the service was on 8 August 2017, when it had met the requirement notices we had issued at the comprehensive inspection in July 2016.

Our inspection team

The team that inspected the service comprised a CQC inspector, a CQC inspection manager and two specialist advisors with experience of working with patients with personality disorders. This included one nurse, and one specialist consultant psychiatrist.

Why we carried out this inspection

We conducted an unannounced, focussed inspection of the service as we had received concerns from a whistleblower and local GP services about the care being provided there. Specifically, around the leadership, the clinical model and the reporting and management of incidents. These concerns related to the following key questions:

- Is it safe?
- Is it effective?
- Is it well led?

Due of the focused nature of this inspection, we did not re-rate the service. We found no breaches of regulations.

How we carried out this inspection

This was an unannounced, focussed inspection to follow up on specific areas of concern. We therefore only looked at the key questions, 'are services safe, effective and well-led'.

Before the inspection visit, we reviewed information that had been raised by other organisations, and information provided by the provider.

During the inspection visit, the inspection team:

- visited all three wards at the clinic, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with two patients who were using the service; a number of patients were on leave and others did not want to speak to us

Summary of this inspection

- spoke with the head of care for the clinic
- spoke with six other staff members; including a doctor, healthcare assistants, an assistant psychologist, quality improvement lead and the maintenance lead
- looked at five care and treatment records of patients, as well as nine medicines charts
- reviewed 13 of the 64 incidents that had occurred in May 2018 up to the day of inspection
- carried out a specific check of the medication management at the clinic
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke to two patients at the clinic, both felt that the permanent staff were caring, kind and helped keep them safe. They said that in the past, lots of agency staff had been used and this was less preferable.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

As this was a focussed responsive inspection, we did not change the ratings. Safe remained as good. We found that:

- The service had a well-maintained, clean and safe environment. Staff undertook audits to monitor safety, and there were adequate lines of sight. Staff also had access to alarms.
- Staffing had been a problem in the year prior to this inspection but at the time of the inspection the staff team was more stable, with decreasing use of bank staff to cover shifts, lower staff turnover and a low number of vacancies. This meant that apart from in exceptional circumstances, patients leave and one to one time with staff was not re-arranged.
- Staff assessed patients risk throughout their time on the wards, and had robust systems in place to pass information about escalating risk to each other. Staff were confident and competent in raising safeguarding alerts.
- When serious incidents occurred, staff demonstrated learning and made changes to process to help keep patients safe. We saw from the incidents reviewed that the team reported incidents appropriately both internally, and also to external bodies such as the CQC.

Good



Are services effective?

As this was a focussed responsive inspection, we did not change the ratings. Effective remained as good. We found that:

- Care records included comprehensive and holistic assessments of the patient's needs. We reviewed five out of 16 records and saw that staff updated these records appropriately and patients received care that was recovery focussed.
- Patients had access to recovery based activities on the ward as well as psychoeducational groups. Therapy was delivered using techniques from therapies recommended by the National Institute for Health and Care Excellence. A clinical psychiatrist had been employed to increase patient access to nationally recommended therapies.

Good



Summary of this inspection

- Clinicians at the clinic tracked patients' progress and symptom severity using nationally recognised measures such as Beck's depression index. They also took part in ongoing clinical audits but the recent change in provider meant the new system was still being embedded.
- Staff came from a variety of professional backgrounds, including nursing, psychology, psychiatry and occupational therapy. Staff received an appropriate induction and the service held internal training on working with patients with personality disorders. Staff felt the team was supportive. They had access to group and individual supervision in line with the providers' policy.
- The staff had good working relationships with the funding bodies of the patients placed there, as well as good links with the local safeguarding team and A&E departments. The team was in the process of setting up a memorandum of understanding with local GP practices to help patients benefit from a better network of care.

Are services caring?

Since our inspection in August 2017, we have received no information that would make us re-inspect this key question.

Outstanding



Are services responsive?

Since our inspection in August 2017, we have received no information that would make us re-inspect this key question.

Good



Are services well-led?

As this was a focussed responsive inspection, we did not change the ratings. Well-led remained as good. We saw that:

- Staff felt supported by the service's leadership. They said they knew the managers in their organisation and felt they were receptive to suggestions for service development.
- Staff worked towards a defined recovery orientated goal for each patient. Aiming to help them achieve the best outcome of treatment, they could.
- Managers kept track of service performance using comprehensive audit systems. They used key performance indicators for the team in individuals' supervision framework. This meant that staff could focus on driving improvement in the service through their supervision.
- The service had recently made the decision to participate in the Accreditation for Inpatient Mental Health Services scheme (ran by the Royal College of Psychiatrists) and were working towards this.

Good



Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff we spoke with were knowledgeable about the Act, and knew where to get advice. Seventy-two per cent of staff had received training in the Mental Health Act.

Patients confirmed staff had read them their rights, and that they understood them. They could also access an advocate and the advocates contact details were prominently displayed in the clinic.

The service had a Mental Health Act administrator that could provide advice, and monitored the paperwork associated with the Act.






Mental Capacity Act and Deprivation of Liberty Safeguards

Seventy-two per cent of staff were up to date with their training on the Mental Capacity Act. Staff were able to demonstrate how they worked within the legislation and had an awareness of the principles of the Mental Capacity Act.

There were no patients under a deprivation of liberty safeguard at the time of this inspection.

Long stay/rehabilitation mental health wards for working age adults

Good 

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

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

Good 

Safe and clean environment

- Staff could observe the wards safely. Staffing levels were adjusted to meet the needs of patients on enhanced observations (such as having a staff member within arm's reach). There were also fixtures such as parabolic mirrors to help mitigate risk in areas on the ward that were not immediately visible.
- Managers ensured the safety of the environment was checked. There were checks for fire safety, the boiler, kitchen appliance and an environmental ligature audit. A ligature audit covers an inspection of an environment for points that could be used to tie a cord or similar for the purpose of self-strangulation. This audit was up to date. However, while it showed the actions needed to be taken, it did not show dates when these actions had been completed. We brought this to the attention of staff and they acted on this immediately.
- The wards were for female patients only so met Department of Health guidance on mixed-sex accommodation.
- There was a well-maintained clinic room. Staff undertook checks to ensure medicines were stored at correct temperatures (to not reduce their shelf life) and checked the emergency equipment located at reception and in the clinic room.
- There were no extra care areas, or seclusion rooms where patients might be separated from the wards.

- The service was clean, tidy and in good repair. Cleaning logs for the service showed regular and in-depth cleaning had taken place. The maintenance lead demonstrated regular and prompt repairs had taken place.
- Staff undertook appropriate infection control measures, and there were posters around the clinic to remind staff and patients on correct hand washing techniques.
- Staff had access to working personal alarms, and they responded quickly when the alarm was raised.

Safe staffing

- Staffing levels had improved at Alders clinic. The clinic had the equivalent of 59 full time staff, including clinical and non-clinical staff. This was above the establishment number of 44. There were two, part time posts, for a weekend cook, and an occupational therapist. There had been a declining trend in the use of bank staff since April 2017 (where 1305 hours were logged) and March 2018 (where 638 hours had been logged). Agency staff had been used in 206 shifts in the year before this inspection, this usage was greatest in March and April 2018.
- Management set staffing levels according to patient needs and the number of patients at the service. Staffing ladders were used, with a minimum of one qualified nurses per shift and three or four healthcare assistants on duty when patient numbers were low. From reviewing the rota, it was common in the three months before this inspection for two nurses and seven or eight healthcare assistants to be on shift. The peak in the need for bank and agency staff was explained by the escalating needs of some patients who had been

Long stay/rehabilitation mental health wards for working age adults

Good 

waiting for transfer to more suitable placements. We saw an example where a registered general nurse had been employed to meet the particular physical health needs of a patient unable to attend a local GP.

- Agency staff were inducted to the ward, and were selected based on prior experience of working at the clinic. Where possible, service manager block booked staff to help ensure continuity. Patients said that while agency staff were not as helpful for them, they felt safe on the ward and enjoyed being cared for by permanent staff.
- For the majority of shifts, staffing numbers met the establishment levels. There were two night shifts that were short of a healthcare support worker but there had been no incidents leading to harm on these shifts.
- Staffing levels were generally enough to allow staff to have one to ones with their patients and assist with escorted leave. Patients said that their planned activities might be postponed in exceptional circumstances.
- There had been problems with staff turnover in the past. However, this had improved in recent months, with the first quarter of the year having a turnover of 7% and the turnover in April 2018 only being 2%. Staff sickness in April 2018 was also 2%.
- Mandatory training had been completed by staff. Overall, 92% of staff were up to date with their mandatory training. The only training where less than 75% (CQCs benchmark of good practice) of staff were up to date was the Mental Health Act, Mental Capacity Act and Deprivation of Liberty safeguards training which was 72%. Mandatory training included specialist training on working with patients with personality disorders.
- Staff reported rapid access to a psychiatrist when needed, and adequate medical cover out of hours should there be an emergency.

Assessing and managing risk to patients and staff

- The service did not use seclusion. There had been no incidents of seclusion or long-term segregation in the six months before this inspection. Staff did use restraints and rapid tranquilisation medicine where required. Rapid tranquilisation medicine is used to calm a patient when they are aggressive and posing a risk to themselves or others. Staff had recorded 29 incidents of rapid tranquilisation being used in the six months before this inspection. There had been 47 recorded

restraints in this time period; none involved the patient being held in the prone position. Staff adhered to national guidance when they administered rapid tranquilisation medicine.

- Patient risks were regularly assessed and updated during their admission. Patients were assessed in depth over the first 72 hours of their admission to form a care plan around risks and their needs. After this, staff used daily risk assessments to feed into a patient's care plan and highlight risks at handovers as well as discussing patients risks at multidisciplinary meetings.
- The ward used an approach of positive risk taking to help patients recover and prepare for life outside the ward. This meant restrictions were based on patient risks, and typically were applied individually. At the time of this inspection, there was one blanket restriction on one of the wards of the service based on a patient's risk.
- Informal patients were able to leave at will. There was an airlock door that was kept locked but there was adequate signage to remind people that if they were not detained, they could request staff to let them out of the service.
- We saw that observation levels of patients were determined based on the patient's risk. Where incidents had happened while patients were under staff observation, lessons were learned and actions taken to mitigate future events occurring.
- Staff made 15 referrals to the local safeguarding team in the six months before this inspection. They could explain how they identified a safeguarding concern and knew the process to follow to keep people safe.
- The service had a separate visitors room in reception to facilitate safe and observed (where necessary) visits by a patient's family or children.

Track record on safety

- There had been two serious incidents in the six months before this inspection. One of these had required police to disarm a patient holding a weapon. We saw that staff had reflected on the incident, disseminated the learning from it and had recruited a new staff member with specific skills to remove the risk of the incident happening again.

Reporting incidents and learning from when things go wrong

- Staff were aware and comfortable with the processes used to raise risks within the service. They said that

Long stay/rehabilitation mental health wards for working age adults

Good 

these processes were clear, supportive and allowed them time to debrief both as a team, and individually. We saw evidence that these incidents were reported to the patients funding body and the CQC where relevant.

- When serious incidents had taken place, staff were aware of their duty of candour and their obligation to be clear, open and honest about what had gone wrong.
- Staff had weekly meetings where they discussed risks and incidents, and shared any learning. The head of care at the service also attended monthly meetings held with other heads of care across the provider to share learning from incidents that had occurred at their service as well as learn from incidents that had occurred elsewhere.
- We saw ample evidence of changes to practice following incidents, including new resources being acquired, changes to procedure and wider learning and changes to patients' care plans. While up to date national data is not available on the number of incidents typical in services for women with personality disorders, our expert specialist advisors saw that the type of incidents were typical in their experience and that when incidents occurred, staff reacted appropriately.

Are long stay/rehabilitation mental health wards for working-age adults effective?
(for example, treatment is effective)

Good 

Assessment of needs and planning of care

- Staff maintained up to date and holistic assessments of patients' needs. We reviewed five records and saw that in only one case, an initial physical health assessment had not been completed by the doctor but we saw robust physical health assessments following this. In all of the records, staff had highlighted patients' recovery needs and the steps needed to meet those needs. These were regularly updated from both multidisciplinary meetings with the patient, and the daily risk assessments and handovers.
- Patients at the service often had a variety of physical health needs, appointments to local hospitals and GP

services were facilitated by staff. The provider was drawing up a memorandum of understanding with local GP services to help strengthen the network of care that patients could benefit from.

- Care records were kept electronically, in a password-protected system. Daily notes and updates from the handovers were put onto this system to ensure staff had timely access to up to date information.

Best practice in treatment and care

- We reviewed nine medication charts and saw that prescriptions for medicines such as antipsychotic medicines were within national guidance such as that provided by the National Institute for Health and Care Excellence (NICE).
- Access to psychological therapies recommended by the National Institute for Health and Care Excellence was improving. Patients had a timetable of therapeutic activities and a program of psychoeducational groups. Staff in the service used techniques from cognitive behavioural therapy and dialectical behavioural therapy to help patients. A new clinical psychologist had been appointed to improve patients access to one to one therapies recommended by the National Institute for Health and Care Excellence.
- Staff used a variety of nationally recognised rating scales to assess and record patients' clinical outcomes. For example, the health of the nation outcome survey, a provider wide risk assessment and Beck's depression inventory.
- There was an audit program in place that staff completed. However, due to the recent change in provider, a new system was being embedded.

Skilled staff to deliver care

- There was a range of staff from different therapeutic disciplines on site and available to patients. The service had recently hired a psychologist to help increase patient access to psychological therapies, but patients benefited from nursing staff, a dietician, psychiatrists and occupational therapists. Where needed other specialists were hired, including the sourcing of a part time registered general nurse for a patient. These staff were experienced and qualified for their role and had the benefit of additional training in house on working with patients with personality disorders.
- All staff took part in an induction process. This included a checklist of tasks and competences and completion of

Long stay/rehabilitation mental health wards for working age adults

Good 

all mandatory training. Staff had access to both formal and informal group and individual supervision. There were weekly formulation meetings, handovers and staff received individual supervision monthly during their induction, and once per six weeks afterwards.

- Managers dealt with poor performance and helped staff to better perform their role.

Multi-disciplinary and inter-agency team work

- The team held effective team meetings throughout the week that involving a variety of staff. There was a meeting on Mondays that was attended by every available member of staff, as well as a rotating pattern of meetings to assess individual patients across the month.
- Staff reported good links with local A&E departments and the police. They also reported a good working relationship with the local safeguarding team and the different funding bodies that placed patients at the clinic. Relationships with the local GP service were being strengthened by drawing up a memorandum of understanding.

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

- Seventy two percent of staff were up to date on their Mental Health Act (MHA) training. Healthcare assistants had the lowest completion rate with 68% being up to date. However, there was a MHA administrator that staff could access for guidance.
- There was a clear understanding from staff about the various restrictions being detained under the Act entailed, and staff demonstrated a good understanding of the Code of Practice and the Act.
- Patients confirmed that they had been presented their rights under the Act, and were reminded of these appropriately. They had access to an independent mental health advocate and there was information about how to contact them and the patients' rights on display. At the time of this inspection, 12 out of 16 patients were detained under the Act.
- The Mental Health Act administrator audited and monitored the paperwork associated with the Mental Health Act monthly.

Good practice in applying the Mental Capacity Act

- Seventy-two per cent of staff were up to date on their Mental Capacity Act (MCA) training. Healthcare

assistants had the lowest completion rate with 68% being up to date. However, staff gave examples of working within the scope of the Mental Capacity Act. They were able to talk about how they had made a decision specific assessment for one person regarding their finances. They were aware of who to include in a best interest decision.

- None of the patients were under a deprivation of liberty safeguard at the time of this inspection.
- Staff could explain the principles of the Mental Capacity Act and had a policy they could access to assist them.

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

Outstanding



Since our inspection in August 2017, we have received no information that would make us re-inspect this key question.

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

Good



Since our inspection in August 2017, we have received no information that would make us re-inspect this key question.

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

Good



Vision and values

- The current provider had very recently acquired the service and new corporate values were being

Long stay/rehabilitation mental health wards for working age adults

Good 

embedded. However, all staff we spoke with were aware of their definition of recovery and the goal of helping patients achieve the best outcome from treatment they could.

- There was a clinical model in place for staff to work towards, and staff were genuinely signed up to the principles of it to help patients recover.

Good governance

- The changeover of provider had meant that new governance processes were still being implemented. However, we did see evidence of staff ensuring they continued to collect information to ensure the service improved and maintained good performance. We noted several examples where incidents had led to practice changes as well as evidence of the clinics approach to learning from incidents and keeping patients safe while preparing them for life after treatment at the clinic.
- Key performance indicators were used to guide performance, and these also formed part of staffs' supervision.

Leadership, morale and staff engagement

- Staff said the team benefited from strong local leadership. They were aware of the managers in their structure and had been visited by senior managers

within the organisation. While some of the leadership team were new, they reported strong support in their role, and this supportive environment was echoed by other staff we spoke with.

- There had been a time of staff turnover in the year before this inspection. However, staff reported that things had stabilised and they felt the team worked well together to care for patients.
- All staff felt able to raise concerns and felt these would be addressed in a meaningful way. None of the staff we spoke with reported any cases of bullying or harassment, or victimisation when raising concerns.
- We were shown an example of when staff had suggested improvements to service delivery and this had taken place. A member of staff had suggested physical health clinics at the clinic to improve consistent recording of patients' physical health. This had been implemented.

Commitment to quality improvement and innovation

- Staff were able to describe how provider wide groups were able to feedback on performance data to help the clinic improve.
- The clinic was also applying for Accreditation for Inpatient Mental Health Services scheme, though this had not taken place at the time of this inspection.