

Cygnet Lodge Lewisham

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?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Lodge Lewisham as good because:

- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the ward. These included occupational therapists, nursing, psychologist and a consultant psychiatrist. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing recovery.
- Staff worked hard to provide safe care in most areas. The service had enough nurses and doctors with the right skills and qualifications. Staff assessed and managed risk well. Staff completed risk management plans in collaboration with patients in their 'my safety plan'. Ligation risks had been assessed and fire safety arrangements were in place. Staff carried out regular physical health checks such as blood tests and monitoring patients' vital signs.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients, families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. Discharge planning arrangements were well defined within patient care plans and started approximately six months following a patient's admission.
- The service had a pathway for rehabilitation which outlined timeframes and what the patient could expect from the service.

- The service worked to a recognised model of mental health rehabilitation. Governance processes operated effectively at ward level and senior management level. Staff managed performance well. The service took part in internal quality reviews of the hospital to ensure the effectiveness of the service.

However,

- Some parts of the building were run down and required extensive maintenance and refurbishment, including patient bedrooms. The provider had a schedule of works planned to improve the decoration and maintenance of the building. However, some parts of the schedule of works were not taking place until 2020, rather than sooner.
- Patient bedrooms did not provide a therapeutic environment for patients to recover. Bedrooms were bare and contained old furniture that needed replacing.
- Staff did not always store controlled drugs safely. During the inspection we found the controlled drug cupboard unlocked and the keys with the manager rather than the nurse in charge.
- Even though the service reviewed blanket restrictions every six months, staff imposed a blanket restriction on patients. After every meal staff collected cutlery back in, counted it and recorded that it was all there. This was not based on a patients' individual need.
- Staff did not always actively promote the needs of all patients, including those with a protected characteristic. The service could do more to encourage an open and inclusive environment to support patients' sexual, cultural and spiritual preferences.

Summary of findings

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Good 

Cygnnet Lodge Lewisham

Services we looked at

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

Summary of this inspection

Background to Cygnet Lodge Lewisham

Cygnet Lodge Lewisham is an independent hospital for 17 male adult patients. The hospital is run by Cygnet Health Care (one of several hospitals it runs throughout the country). At the time of the inspection, 16 patients were receiving treatment at the service.

The service is registered with the Care Quality Commission to provide the following regulated activities:

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

The service has a registered manager.

The service is a long-term, high dependency rehabilitation unit. All patients are subject to detention under the provisions of the Mental Health Act at the point of admission. Patients at Cygnet Lodge Lewisham have a

primary diagnosis of mental illness such as schizophrenia, schizoaffective disorder, bipolar affective disorder or depression. Most patients had additional complex needs, such as Ministry of Justice restrictions, substance misuse or physical health problems.

We previously inspected Cygnet Lodge Lewisham in June 2016 when we rated the service as 'good' overall. At that time, we rated safe, caring, responsive and well-led as 'good'. We rated effective as 'requires improvement'. At that inspection, we found that some legal requirements were not met. We had concerns that the service did not have enough staff to meet patients' needs. We issued one requirement notice for breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. This notice related to breaches of regulation 18 (Staffing).

Our inspection team

The team that inspected the service comprised two CQC inspectors, an assistant inspector, a specialist nurse who had experienced working in long stay/rehabilitation wards and an expert by experience. An expert by experience is someone who has previously used services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with eight patients who were using the service;

Summary of this inspection

- spoke with the registered manager and senior managers within the organisation;
- spoke with eight other staff members; including doctors, nurses, occupational therapist, clinical psychologist and social worker;
- attended and observed a patient activity;
- looked at six care and treatment records of patients;
- carried out a specific check of the medication management; and
- 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 with eight patients during the inspection. Most of the feedback was positive. Patients told us what they most liked about the service was the staff and how they treated them. Patients said staff supported them with budgeting, personal care and shopping.

Patients completed a satisfaction survey based on their care and treatment at the service. Eighty-three per cent of patients said that ward staff were caring and supportive. Ninety-two per cent of patients said they felt safe at the service. In addition, 54% of patients said they felt involved in their care and treatment.

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?

We rated safe as requires improvement because:

- Some parts of the building were run down and required extensive maintenance and refurbishment, including patient bedrooms. The provider had a schedule of works planned to improve the decoration and maintenance of the building. However, some parts of the schedule of works were not taking place until 2020, rather than sooner.
- Staff did not always store controlled drugs safely. During the inspection we found the controlled drug cupboard unlocked and the keys with the manager rather than the nurse in charge.
- Even though the service reviewed blanket restrictions every six months, staff imposed a blanket restriction on patients. After every meal staff collected cutlery back in, counted it and recorded that it was all there. This was not based on patients' individual needs.
- Two out of the five nursing staff we spoke to could not identify where potential ligature points were within the hospital and the risks associated with them. This meant some staff would not be adequately equipped to deal with patients who attempted to self-harm.
- Staff did not adequately store and label patients' food in the assisted living kitchen fridge.

However,

- Staff and patients worked collaboratively when completing risk management plans. Risk assessments and management plans were reviewed and updated regularly. Risk management plans contained information specific to patients' physical and mental health needs.
- 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.
- Staff monitored patients' physical health. Staff used the National Early Warning Score to assess and monitor patients' physical health risks. Staff recorded and responded when a patient's physical health deteriorated.
- 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.

Requires improvement



Summary of this inspection

- The service had enough staff to ensure that patients could be escorted into the community and kept safe.
- The ward had a good track record on safety. 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.

Are services effective?

We rated effective as good because:

- Staff assessed the physical and mental health of all patients on admission. Staff developed individual care plans, which they reviewed regularly through multidisciplinary discussion. Patients' care plans were personalised, outlined the patient's assessed needs, and were recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for patients in recovery and rehabilitation. This included access to psychological therapies to support self-care, developing everyday living skills, and meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- At the last inspection in June 2016, the provider did not have enough multidisciplinary staff to ensure patients had access to a full range of therapeutic activities. At this inspection, improvements had been made. 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.
- Staff supported patients to make decisions on their care for themselves. They understood the main principles of the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Good



Are services caring?

We rated caring as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. Patients provided mostly positive feedback about staff and how they were treated.
- 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.

Good



Summary of this inspection

- Patients fed back that staff treated them with dignity and respect. We observed positive interactions between patients and staff. Staff spoke to patients in a kind, respectful and friendly manner.

Are services responsive?

We rated responsive as good because:

- Staff planned and managed discharge well. Staff worked collaboratively with other professionals to ensure that patients moved on to suitable placements. Staff worked hard to engage patients who had stayed at the service for a significant amount of time and were not yet ready for discharge.
- Patients came from low secure forensic wards or acute wards and were mostly from the London area. A few patients came from outside London in nearby counties.
- Staff supported patients to access the local community. Staff supported patients to become involved in community-based activities as part of their rehabilitation and recovery.
- The food was of a good quality and patients could make hot drinks and snacks at any time. The occupational therapist assisted patients to cook their own meals.
- The service treated concerns and complaints seriously. Staff investigated complaints and the lessons learned were shared with the team and the wider service.

However,

- Staff did not always actively promote the needs of all patients, including those with a protected characteristic. The service could do more to encourage an open and inclusive environment to support patients' sexual, cultural and spiritual preferences.
- Staff did not provide a therapeutic environment for patients in their bedrooms. Patients bedrooms needed new furniture and decorating. This could impact on patients' recovery if they did not have a therapeutic and homely personal space to use.

Good



Are services well-led?

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles. The managers had a good understanding of the services they managed. Senior managers were visible in the service and approachable for patients and staff.

Good



Summary of this inspection

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The service worked towards a model of recovery and rehabilitation to support patients.
- Governance processes operated effectively at ward level and senior management level. Staff managed performance well. The service took part in internal quality reviews of the hospital to ensure the effectiveness of the service.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- There was clear learning from incidents. Staff discussed incidents monthly at the team meeting.

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.

All patients were detained under the Mental Health Act 1983. Staff understood their roles and responsibilities under the Mental Health Act 1983, the code of practice and its guiding principles.

Staff authorised and administered medicines for detained patients in line with the Mental Health Act Code of Practice. Staff explained to patients their rights under the Mental Health Act in a way they could understand.

Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff had a good understanding of the Mental Capacity Act and the five statutory principles. Staff knew how to support patients who lacked capacity to make decisions about their care.

Staff completed capacity assessments for patients that might have impaired capacity. These were time and decision specific. Staff understood the need to seek consent from patients before providing care and treatment.

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	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

Long stay or rehabilitation mental health wards for working age adults

Good 

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

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

Requires improvement 

Safe and clean environment

Staff carried out regular risk assessments of the environment. This included an annual review of fire safety. The service used an external health and safety company to carry out checks on fire safety and produce an action plan. The service last had an inspection in November 2018. The actions addressed fire extinguishers being correctly located and correct signage to be displayed throughout the hospital. Staff had completed most actions and reduced the risk. However, an action to seal and cover holes and gaps in ceilings and floors, rated as a moderate risk had not been fully completed. We found a patient's en-suite bathroom had holes on the floor. Staff immediately made the floor safe when this was brought to their attention. Plans were in place for all flooring to be made safe as per the action plan by 1 September 2019.

The service mostly managed ligature risks in the environment appropriately and safely. The service had potential ligature anchor points in the service. However, patients were deemed low risk for self-harm and suicide and staff knew the patients very well. Staff further reduced the risk of patients by carrying out observations, when needed, and two-hourly walkarounds as a minimum.

Staff had updated ligature risk assessments and added photographs of key ligature points to help staff identify them. However, not all staff knew about potential ligature

anchor points. Two out of five nursing staff we spoke to could not tell us what ligature points were and how patients could potentially harm themselves. This meant that staff may not be adequately equipped to deal with patients who attempted to self-harm.

There were some blind spots throughout the ward where staff could not always view patients in communal areas. The service had taken appropriate steps to manage and mitigate the risks associated with blind spots by installing closed circuit television in communal areas.

Staff had easy access to personal alarms, which meant they could summon assistance if there was an emergency. Staff knew how to use them. Staff also had two-way radios so that they could communicate with colleagues in other parts of the hospital.

The service was visibly clean in communal areas but not well maintained and clean in all parts. The service had recently refurbished and redecorated some parts of the communal areas such as the dining room and living room. However, patients' bedrooms had not been adequately maintained or kept clean. For example, one patient's en-suite bathroom had a hole on the floor with ants crawling out of it. Another patient bedroom had writing on the wall from some time ago when they were first admitted. This had not been painted over. Another patient bedroom was unbearably hot. Most patients' bedrooms had dirty walls and needed painting. In addition, bedrooms all had strong odours inside them. Staff said they encouraged patients to tidy and clean their rooms, but this could be difficult when patients did not want to engage. This meant that patients' private space was not adequately maintained and clean. Senior management shared their action plan for works and redecoration scheduled over the rest of the year and into 2020. Whilst staff covered the hole in the floor

Long stay or rehabilitation mental health wards for working age adults

Good 

immediately and planned to commence refurbishing this en-suite, some bedrooms still had to wait longer to be redecorated and receive new furniture. For example, several bedrooms had been listed to receive new furniture by March 2020, which was a long time to use unsuitable furniture. General redecoration of bedrooms was not listed on the action plan as work to be done. We raised this with the manager. Since the inspection, the provider has arranged for all patient bedrooms to be painted as soon as possible, starting 5 August 2019.

Staff implemented infection control policies and procedures and worked to try and reduce the risk of infection, but there was still work to be done. Staff disposed of sharps waste in a sealed sharps waste bin. Staff checked food fridge temperatures. However, the occupational therapy kitchen fridge contained out of date food and there was no clear process for how staff would check this. The manager said the occupational therapist was meant to check the food and fridge temperatures but there was no log of this. We found some out of date chicken in the fridge. This meant that patients could be at risk of food contamination and bacterial diseases.

Staff completed quarterly infection control audits. We looked at the most recent one completed in July 2019. The audit identified, poor quality of bedrooms, the need to clearly label food stored in fridges and ensure there were no gaps in the cleaning schedules. However, these all had 'ongoing' as to when the actions should be addressed by, which did not ensure staff would clearly complete these actions by a fixed date.

Clinic room and equipment

The service had appropriate premises and equipment and staff looked after them well. The clinic room contained the necessary equipment to carry out physical health examinations and emergency procedures. Staff checked the medicines fridge and room temperature readings each day. The daily records for the fridge temperatures showed these were within the correct range.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. This included an emergency grab bag, blood pressure machines, thermometers, weighing scales, blood sugar level machines and pulse oximeters. Staff checked the equipment each week to ensure they worked. In addition, staff checked the emergency drug stock to

ensure they were in date. However, we found some glucagon that was one month out of date, which the service's audit had not picked up. This meant staff could still administer this medicine to a patient and it may not have the desired effect.

Safe staffing

The service had enough nursing staff of all grades to keep patients safe. The manager calculated the number and grade of registered and non-registered nurses required on each shift using a recognised tool. The establishment levels were eight whole time equivalent (WTE) registered nurses and 10 WTE non-registered nurses working across the service. Staff worked long day shifts. The day shift consisted of two registered nurses and three non-registered nurses. At night it was two registered nurses and two non-registered nurses. The service had a ward manager working weekdays to oversee the running of the ward, including a hospital director that covered both the service and the provider's other service nearby.

The service had three vacancies for registered nurses at the time of the inspection. One of these vacancies had been recruited to. The service was completing pre-employment checks prior to arranging a start date. The other two nurses had recently resigned.

The manager limited their use of bank and agency staff and requested staff familiar with the service. The manager used extra bank and agency to cover staff sickness, enhanced observation levels and staff vacancies. The manager made sure all bank and agency staff had a full induction and understood the service before starting their shift. This included training in the use of ligature cutters, reading security policies and training in management of violence and aggression.

A registered nurse was always present in communal areas. The service had enough staff for patients to receive regular one-to-one time with their named nurse and to carry out physical interventions. The manager rarely cancelled patients' leave due to staff shortages.

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. A consultant psychiatrist worked full-time at the service and the provider's other service nearby. In

Long stay or rehabilitation mental health wards for working age adults

Good 

In addition, a full-time doctor worked on the premises. An out-of-hours on call rota system operated at the service. This consisted of medical staff across three of the organisation's services in London.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Mandatory training included immediate life support, prevent, prevention and management of violence and aggression and health and safety. Staff also participated in emergency scenario training each quarter. We looked at the emergency scenario training carried out in March 2019 with six members of staff participating in it. This ensured staff would have the practical capabilities and skills needed in an emergency.

Assessment of patient risk

Staff used a recognised risk assessment tool to assist their evaluations of patient's individual risk. We reviewed six patient risk assessments. Records showed that staff completed a comprehensive risk assessment for each patient following admission. This included an assessment of each patient's mental, physical and social risk history.

Management of patient risk

Staff identified and responded to changing risk to or posed by patients. Staff reviewed patients risk every week in the multidisciplinary meetings. Patients contributed to their risk assessments in their 'my safety plan'. This contained the patient's views on how they could reduce the risk to themselves when they felt stressed or anxious.

Patients assessed as having physical health risks, such as diabetes or cardiac problems, had a risk management plan in place. For example, a patient had a risk management plan for his clozapine medicine. Staff regularly checked patients' vital signs and recorded these on a National Early Warning Score chart. Records showed that staff completed these observations daily and escalated any high scores to clinicians. This reduced the risk of patients' physical health deteriorating rapidly unnoticed.

Staff and patients adhered to a smoke-free policy. Staff did not allow lighters or cigarettes on the premises. Patients stored their cigarettes and lighters in their own storage boxes in lockers outside the service. However, there were only three lockers and most patients smoked, so some

patients may take other patients' cigarettes. The manager said there was plans in place to install more lockers outside. There was no timescale for this. Patients could also use electronic cigarettes in their bedrooms.

The ward had an appropriately worded sign at the exit doors explaining to patients their right to leave if they were admitted informally. However, at the time of the inspection, all patients were detained under the Mental Health Act.

Use of restrictive interventions

The service analysed incidents of physical restraint on the ward. Between October 2018 and June 2019, the service recorded one incident of physical restraint. This restraint was in the prone position and had resulted in rapid tranquilisation. Staff recorded this incident of restraint appropriately. For example, how the restraint was carried out, which staff were involved and for how long.

Staff understood and used correct techniques when using physical interventions. Staff only used restraint after de-escalation had failed. Staff devised plans to manage behaviours that challenged.

Staff told us that detained patients who went absent without leave (AWOL) usually returned or made contact and came back on their own accord. However, there had been a rise in the number of patients going AWOL in the service recently. This was mainly one patient. Staff discussed ways they could reduce him absconding without being punitive and putting in more restrictive measures.

Staff were working to reduce blanket restrictions but there was further work to do. The manager completed a blanket restrictions audit every six months to review the use of blanket restrictions and ensure staff were not applying unnecessary restrictions on patients. At the time of the inspection, staff carried out random room searches on all patient bedrooms. Staff said this was to check for maintenance issues and for contraband items such as illicit substances. In addition, the service had recently changed their policy for patients using cutlery. Staff counted cutlery back in after each meal and recorded this. The manager said this was to a decision they took in a recent team meeting to keep staff safe from possible injury with a weapon by a patient. This was not appropriate as it meant that patients were at risk of not receiving support in a manner that reflected their needs and preferences in a rehabilitation unit.

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff knew and followed the provider's observation policies and procedures. The multidisciplinary team assessed the levels of observation the patients needed. Most patients were on hourly observations or intermittent observations. Staff always changed observation levels when a patients' risk changed. In addition, staff carried out twice daily checks on the environment.

Patients who needed them, had a personal emergency evacuation plans to follow in the event of a fire or other emergency.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding alert and raised alerts appropriately. All staff had received training in safeguarding vulnerable adults and children from abuse.

Staff gave us examples of safeguarding concerns they had reported. This included incidents of financial abuse and physical abuse. The service had reported one safeguarding concern to the local authority between November 2018 and June 2019.

The service had a safeguarding lead. This meant staff had a person they could ask for advice and guidance if they were concerned about a patient's safety. The safeguarding lead had attended extra training to provide staff with support and updates on safeguarding incidents.

Staff followed safe procedures for children visiting the ward. Adult visitors always accompanied children. There was a designated place for visitors to meet patients.

Staff access to essential information

Staff kept patients' care and treatment records on an electronic management system and in paper format (prescription charts and physical health observations). All information needed to deliver patient care was available to all relevant staff, including agency staff, when they needed it. The service planned to move care plans on to the electronic system so that all patients' records could be found in one place.

Medicines management

Staff ordered, dispensed and disposed of medicines safely. We checked medicines administration records of five patients. Patients' prescription charts included important information, such as patient allergies, and were kept with records of patients' blood tests and electrocardiograms.

This meant that when medicines were prescribed, information regarding patients' physical health was readily available. The service contracted an external pharmacist who attended the ward once a week. The pharmacist completed weekly audits of room and fridge temperatures, storage, medication errors and stock checks.

Although staff had stored most medicines safely during the inspection we found the controlled drugs (CD) cupboard had been left unlocked. Staff said this was normally kept locked. The nurse in charge did not have the CD keys on their person to lock the cupboard. They said these were kept with the manager and separate from the medicine's keys. When we asked the manager, they said that policy is for the CD and medicines keys to always be kept with the nurse in charge. This confusion did not ensure that CDs were kept safely and could not be diverted.

Staff reviewed the effects of medicines on patients' physical health regularly and in line with the National Institute Health and Care Excellence (NICE) guidance, especially when the patient was prescribed a high dose of antipsychotic medication. We looked at the records for two patients who had been prescribed high doses of antipsychotic medicines to manage their mental health. Staff safely monitored patients for the side effects of these medicines or adverse reactions.

Track record on safety

Between January 2019 and June 2019 there was one serious incident reported by this service. This was an unexpected death of a patient whilst in the community. The provider had completed an investigation in to the death and attended the coroner's inquest. Staff and patients were debriefed and provided with support after the incident.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff reported all incidents they should report. Since January 2019, staff had reported four incidents at the service. These included an unexpected death, medicines errors and a patient absconding from leave.

Staff were aware of a serious incident, which had occurred in another service within the organisation. Staff received monthly learning bulletins about serious incidents and themes that had occurred in other services. For example, in

Long stay or rehabilitation mental health wards for working age adults

Good 

May 2019, staff received a bulletin about areas of concern found at another service within the organisation that could impact on the care and treatment they provided to patients. Staff discussed this bulletin in their monthly team meeting.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong.

The service supported staff and patients after a serious incident had occurred. Staff met to discuss feedback after incidents. For example, after an unexpected death occurred in the service, staff and patients received a debrief afterward with the lead psychologist. The psychologist offered support to staff and put mechanisms in place to help staff.

Staff made changes in response to feedback from initial incident investigations. For example, staff discussed an incident where a patient had been inappropriately admitted to the ward. Staff ensured everyone followed the agreed exclusion criteria in the future and all new referrals were discussed as a multidisciplinary team.

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

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

We reviewed six patient care and treatment records during our inspection. Records demonstrated good practice in terms of assessment, treatment and risk management. Staff completed a comprehensive mental health assessment of patients in a timely manner at, or soon after, admission. Staff from the assessment team visited patients before they moved to the service to complete a comprehensive assessment to ensure they were suitable for rehabilitation.

Staff recorded patients' physical health needs and updated care plans to reflect this. For example, one patient had a specific care plan for treating and supporting him with his diabetes. Another patient had a care plan for their risk of choking. The patient had been assessed by a speech and language therapist who produced a meal plan for him. This ensured staff knew how to support patients.

Care plans were personalised, holistic and recovery-orientated. Staff demonstrated optimism in patient's recovery. Staff adopted a recovery oriented, personalised approach with patients. Patients had personal timetables reflecting their personal interests and specific needs. Care plans included patients' own recovery-oriented goals. For example, one patient had goals that reflected their financial and budgeting needs as well as their personal care needs. However, staff did not always complete realistic goals with patients, so they could achieve them and make progress on their recovery journey. For example, one patient had goals to support them with gaining unescorted leave. This patient was under Ministry of Justice restrictions and it was not clear how staff would support him to achieve this goal. The manager said this was due to way the care plan template is set out and they hoped this would improve once the care plans moved to the new electronic system in the next few months.

Patients each had a named nurse and had regular one-to-one key worker sessions as part of their care plan.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff followed National Institute for Health and Care Excellence (NICE) guidance for mental health rehabilitation services and when prescribing medicines.

The service was able to provide psychological interventions in line with NICE guidance. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation.

At the previous inspection in June 2016 we found that the provider did not have enough staff to carry out therapeutic activities with patients and support them to maintain their independence. At this inspection, we found that improvements had been made. The service employed a full-time occupational therapist and two assistant occupational therapists (OT). The service had increased the

Long stay or rehabilitation mental health wards for working age adults

Good 

number of hours that the OT team worked to ensure that therapy and activities could be carried out. The OT had recently resigned, and the service had advertised the post. The manager said the OT post needed to be a higher band and was being advertised as a band six role.

The service encouraged patients' recovery through teaching greater independent living skills. Whilst no patient was self-medicating at the time of the inspection, staff had the tools ready for when a patient could. Staff said a patient had recently self-administered their medication, but this was stopped due to increase in their risk. OTs conducted a range of different activities and groups in addition to individual sessions to support patients' recovery, improve self-management or rehabilitation and everyday living skills. For example, mental health awareness, computer sessions and art groups. The psychologist led a drop-in 'chat café' every week for patients to attend and discuss issues on a one-to-one basis.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff offered smoking cessation support and worked with patients to reduce their smoking. Staff referred patients to the local gym where appropriate. Staff educated patients on eating healthy and exercising more. However, staff found it difficult to always motivate patients to participate. The service had a daily walking group for patients.

Staff used recognised ratings scales to determine severities and outcomes for patients. The OT used the model of human occupation screening tool. Some patients also had wellness recovery action plans to aid their recovery.

The service monitored the effectiveness of care and treatment and used the findings to improve them. The service gathered data on the environment, medicines and the Mental Health Act.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients. The team included skilled staff from a range of disciplines including nurses, an occupational therapist and assistants, a doctor, a clinical psychologist and a social worker.

The manager made sure they had staff with the range of skills needed to provide high quality care. Most registered nurses came from neighbouring NHS trusts or other mental health services before they started at the service.

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 could attend conferences and share best practice through the multidisciplinary team. However, the service had not ensured that nursing staff received the necessary specialist training for their roles. For example, staff had shown an interest in extra training, including cognitive behavioural therapies to support patients but this training had not yet been approved for staff to attend.

Managers supported staff through regular, constructive appraisals of their work. The manager provided staff with supervision. Staff said they received regular supervision and an annual appraisal. Staff took part in regular reflective practice meetings with the lead psychologist to discuss complex cases.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multidisciplinary meetings. Doctors, nurses and other healthcare professionals supported each other to provide good care. Staff spoke positively about how the multidisciplinary team collaborated to provide holistic care from many disciplines. The multidisciplinary team met together daily to hand over any pertinent issues about patient care. The multidisciplinary team also met together weekly to discuss patients' care and treatment with input from the patient and their families.

Staff shared pertinent information about patients at effective handovers within the team. For example, at the beginning of each shift nursing staff met to discuss any incidents, safeguarding or planning from the previous shift. In addition, staff met monthly to discuss the running of the service in team meetings.

Staff had effective working relationships with other relevant teams within the organisation. For example, the senior managers met monthly with the providers of other services nearby to discuss the integrated governance systems. The minutes for the previous months showed staff discussing clinical effectiveness, incidents, staffing, blanket restrictions and discharges. The manager then fed this into the monthly staff meetings to share pertinent issues.

The team had effective working relationships with teams outside the organisation to support patients holistically. Staff regularly liaised with patients care coordinators from local mental health teams to discuss suitable placements

Long stay or rehabilitation mental health wards for working age adults

Good 

for the patients. However, staff often found it difficult to regularly meet and discuss patient care with care coordinators outside of London. Staff also had a good working relationship with the local police.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 (MHA), the code of practice and its guiding principles. At the time of this inspection, all patients were detained under the MHA. MHA training was mandatory, and all staff had completed this.

Staff had easy access to administrative support and legal advice on the implementation of the MHA. The service had a MHA administrator who carried out audits of MHA paperwork. The administrator also ensured patients attended hospital managers' hearings and MHA tribunals. The service had relevant policies and procedures to support staff with their roles relating to the MHA.

Patients had easy access to information about independent mental health advocacy (IMHA). The ward displayed posters with the contact details of the local advocacy service. An IMHA attended the ward each week.

Staff explained to patients their rights under the MHA in a way they could understand and repeated it as needed. When staff explained patients' rights to them they recorded they had done so. Records showed that staff explained to patients their rights under the MHA at least once a month and whenever their MHA status changed. Staff provided patients with written information about their rights every time they explained them. This ensured that patients understood their rights whilst detained under the MHA.

Staff authorised and administered medicines for detained patients in line with the MHA code of practice. For example, clinicians completed patients' consent to treatment forms accurately and kept them with patients' medicine administration records

Staff ensured that patients could take section 17 leave when this had been granted and this was recorded in their records. Clinicians had clearly recorded the start and end date/time of patients' leave and updated this in their care plans.

Staff completed regular audits to ensure the MHA was applied correctly. For example, staff completed audits on patients' detention expiry dates and patients' rights information. These audits ensured that staff complied with the provisions of the MHA and associated code of practice.

Good practice in applying the MCA

Most staff had a good understanding of the Mental Capacity Act (MCA), and the five statutory principles. Staff knew how to support patients who lacked capacity to make decisions about their care. Training for staff in the MCA and deprivation of liberty safeguards (DoLS) was mandatory and all staff had completed the training.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed a patient lacked capacity.

Staff understood the need to seek consent from patients before providing care. For example, staff supported patients to sign declarations that they understood where staff would and would not share their information with others. If patients did not understand, staff recorded that they had discussed this with them in way they could understand.

When patients lacked capacity, staff made decisions in their best interests and recognised the person's wishes, culture and history. For example, records showed staff made a decision in a patients' best interest where they were unable to weigh up the decision regarding their treatment. This meant staff could look at the patient's needs holistically and consider their wishes and history when deciding on next steps.

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

Good 

Kindness, privacy, dignity, respect, compassion and support

We spoke to eight patients. Their feedback was mainly positive. Patients said that they felt that staff were kind and always treated them with dignity and respect. The majority said that what they liked most about the service was the

Long stay or rehabilitation mental health wards for working age adults

Good 

staff and how they treated them. Most patients said that staff supported them with budgeting, cooking, shopping and personal care. However, one patient said that sometimes staff treated them well and sometimes they did not when they were busy.

Staff interacted with patients in a thoughtful and respectful way. We observed a picnic group during the inspection. Staff spoke to patients in an empathetic and kind manner. Staff gave patients help, emotional support and advice when they needed it. General observations throughout the inspection, showed staff speaking to patients in a caring and calm way. Staff spent time to diffuse situations where patients may become distressed.

Staff understood the individual needs of the patients, including their personal and social needs. Staff supported patients to maintain social activities that they had an interest in.

Staff reported they felt able to report concerns about disrespectful or discriminatory attitudes towards patients.

Staff maintained the confidentiality of information about the patients. Staff discussed patients' care in private and covered the whiteboard in the nurse's station, so people could not see patient information. In addition, patients signed a declaration for every aspect of their care where staff may need to share their information, for example, with family members.

Involvement in care

Involvement of patients

Staff involved patients in care planning and assessing risks. Staff oriented patients to the service when they first arrived. Patients received a recovery folder on admission that included information about the service, activities and patient rights.

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Patients said that staff involved them in their care and treatment planning. Staff recorded in patient care plans where they had been involved and signed for a copy, when patients wanted this.

Staff involved patients in decisions about the service, when appropriate. The service had recently started involving patients on recruitment panels to support interviews of potential staff. Patients could also join the integrated

governance meetings as a service user representative. However, at the time of the inspection, there were not any patients who were able to fulfil this role of service user representative.

Staff supported patients to give feedback about the service they received. The service had a 'you said, we did' board, which highlighted any requests or suggestions that patients had made and what actions had been completed. For example, the patients had asked for more links to the community. In response staff set up links with a local mental health organisation and implemented ward jobs. This showed staff listened to patients' feedback.

Staff ensured patients had access to advocates to have their voice heard.

Involvement of families and carers

Staff enabled families and carers to give feedback on the service. Staff invited families and carers to ward rounds. In addition, families and carers could provide feedback to the service through a survey on an electronic device.

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

Good 

Access and discharge

Bed management

The service provided long term, high dependency rehabilitation for patients. At the time of the inspection there were 16 patients. Places were funded by clinical commissioning groups in the areas where patients lived permanently. The service did not have many out of area placements at the time of the inspection. Most patients were from London. Four patients were from Kent.

All admissions came through a centralised assessment team. This team was internal within the organisation but sat separately from the service. This dedicated team screened all admissions and undertook face to face assessments. After the assessment, the multidisciplinary

Long stay or rehabilitation mental health wards for working age adults

Good 

team met and discussed whether the person was appropriate for the service. This meant that it gave staff at the service more time to provide frontline care and support to patients.

The service had clear admission and exclusion criteria for referrers. This included not accepting patients straight from a psychiatric intensive care unit or patients who would not engage in treatment. Staff regularly discussed the impact of accepting patients that were too high risk to the service in team meetings. This ensured staff were clear about the patients they could accept to support patients in their recovery.

Discharge and transfers of care

At the time of the inspection, the discharge from hospital of one patient was delayed. Delays were often due to finding a suitable placement due to the Ministry of Justice restrictions placed on the patients. The average length of stay for patients was 18-24 months. However, a few patients had been at the service for over three years. Since October 2018 nine patients had been discharged from the service. Most went on to step down accommodation.

Staff planned for patients' discharge. When patients were admitted, staff identified any potential barriers that could delay discharge in the future. Staff created individualised discharge plans with patients. In addition, staff set goals with patients that would support them to move on. Care coordinators were invited to care plan approach (CPA) meetings and multidisciplinary team (MDT) meetings. However, staff noted that it was often difficult to get patients' care coordinators from outside of London to attend CPAs and MDT meetings.

The facilities promote recovery, comfort, dignity and confidentiality

The facilities did not always promote patients' comfort, recovery and dignity. Patients had their own bedroom and most shared a bathroom with other patients. Some patients had en-suite bedrooms. Bedrooms looked tired and bare. The furniture needed replacing in all bedrooms. The provider had a plan of works to refurbish patient bedrooms which would take them into next year to complete. This did not ensure a therapeutic environment to aid patients in their recovery.

Staff and patients had access to a full range of rooms and equipment to respond to patients' needs. The service had

an assisted living kitchen, this was due to refurbished as part of the schedule of works taking place. The service had a quiet room, communal living space and dining area. Patients could access a spacious garden.

Patients had a lockable space in their bedrooms for their belongings and space in fridges and freezers to store their own food. Patients had access to hot and cold drinks throughout the day and night.

Patients had a quiet area they could meet with visitors.

Patients had access to therapeutic activities. The occupational therapist developed a timetable for patients to take part in a range of activities. Activities included, cooking sessions, budgeting, gardening and a relaxation group.

Patients' engagement with the wider community

Staff ensured that patients had access to education and work opportunities. The service offered patients ward based jobs, such as gardening and sitting on recruitment panels.

Staff tried to encourage patients to develop and maintain relationships with people that mattered, for example family members. However, staff were not actively aware of the needs of lesbian, gay, bisexual and transgender (LGBT+) patients. Staff had not taken steps to ensure the ward was clearly open and inclusive for LGBT+ patients. The service used to run a successful men's health group that facilitated discussion on sexuality. However, this had stopped as the staff member who ran the group had left. Staff did not receive specific training to make sure they met patients' diverse needs and consider engagement with specific community groups.

Meeting the needs of all people who use the service

The service made suitable adjustments for patients with disabilities to access the premises. The service had a lift that patients, who were less mobile, could use to go up and down rather than use the stairs.

Staff ensured patients obtained information on their rights, how to complain, local services and treatments available through a welcome information leaflet.

Staff provided information in the English language. However, for patients whose first language was not English staff would provide interpreters or source information available in other languages.

Long stay or rehabilitation mental health wards for working age adults

Good 

Patients had a variety of meal choices that supported their dietary requirements. This included foods to meet patients' individual religious needs such as halal or kosher foods. However, the snacks offered did not have much choice for patients who may want to eat healthier or were vegetarian. This did not give patients diversity or healthy choices with meals.

Staff considered patients' cultural, equality and diverse needs to support their recovery. For example, staff supported patients with their spiritual needs. Patients fed back that they would like more time to attend their places of worship. Staff responded by stating that they would facilitate patients' leave to ensure this.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the outcomes. The service received two complaints in 2019. Patients complained about their care and treatment or staff attitudes.

Patients knew how to complain and felt able to do so. When patients were admitted to the service, they signed to say they knew and understood the complaints process. Staff displayed this information on the noticeboards.

When patients complained, staff provided them with feedback from investigations. For example, the manager wrote to the patient and verbally discussed the outcome with them. We looked at the two complaints received and these showed that patients received support from staff in a timely way after they complained.

Managers handled complaints appropriately. The managers kept a log of all formal and informal complaints. The managers discussed complaints with staff at their monthly team meetings and shared any learning that had resulted.

The service received compliments. Some compliments were displayed on notices within the communal areas.

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

Good 

Leadership

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. For example, the manager explained the premise of recovery for patients and emphasised an importance of staff not being punitive when caring for patients.

Staff and patients said they knew who the senior staff team were and that they were approachable. The senior team were visible at the service and had regular contact with patients. The operations manager visited the service regularly and the hospital director worked across the site and the providers other premises nearby. The chief executive had visited the service in April 2019 to complete a quality walkaround.

The service encouraged leadership development including opportunities for staff below team manager level. For example, the previous team manager moved to one of the provider's new services to help set it up. Staff below manager level could access development opportunities through the provider's other services, if there was no availability at this service. This promoted career development.

Vision and strategy

The service had a clear vision and strategy that all staff understood and put into practice. The provider aimed to help people rebuild their living and vocational skills, ready to regain their place in the community. Staff emphasised optimism in patient's recovery and treated them with dignity and respect.

Staff had the opportunity to contribute to discussions about the strategy for the service. For example, staff representatives attended staff representative groups each quarter.

Staff explained how they worked to deliver high quality care within the service's financial means. Even though renovations in the communal areas of the service had started, there was still a lot more work to be done in patient's bedrooms within an adequate timescale.

Culture

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff felt respected, supported and valued. Staff completed a satisfaction survey in 2019 and the results were published in May 2019. Results from the survey indicated that most staff said there was not enough staff to enable them to do their job adequately. The manager completed an action plan in response to the results. The managers responded that this action was completed as they recently recruited an additional registered nurse post to start in September. In addition, the managers continued to be able to book agency staff, when needed, from the same agency.

Staff felt able to raise concerns and knew about the provider's whistleblowing policy and procedures.

Managers dealt with poor performance when needed. For example, when a staff member displayed poor conduct at work, the manager followed the provider's disciplinary procedure.

The ward teams worked well together, and managers ensured this.

The service promoted equality and diversity in the work place and provided opportunities for career progression. The provider implemented the workforce race equality standard (WRES). This is a requirement for services providing NHS funded care. The standard aims to ensure black and minority ethnic staff have equal access to development in the workplace and are treated fairly. This monitored the experience of BME staff within the organisation.

Staff had access to support for their physical and emotional wellbeing in the workplace. The service had an external employee assistance programme that staff could access confidentially. The managers had made sure staff were aware of this service after a serious incident in January 2019.

Governance

The provider ensured there were structures, processes and systems of accountability for the performance of the service. Managers from the service and the provider's nearby location met up monthly for integrated governance meetings. Managers discussed pertinent issues such as incidents, staffing, feedback from patients and performance of both services. This system ensured key messages and learning were communicated from service level to the provider and vice versa. In addition, senior clinical managers attended quarterly medical advisory

committee meetings to check the clinical performance of the service and the provider's other nearby services. Staff discussed best practice, medicines management and physical health. This supported the delivery of safe and effective care.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at service level. The service had an unexpected death in January 2019. Staff investigated this death and made recommendations.

Senior managers monitored the effectiveness and performance of the service. Staff carried out local clinical audits to monitor effectiveness. Staff completed audits to provide assurance on things like medicines and infection control. In addition, the service recently completed an internal quality review prior to the inspection. This was an internal inspection, carried out by a senior manager from one of the provider's other services. We looked at the results for the recent one completed in July 2019. It showed similar areas for improvement that we picked up during the inspection. For example, cleanliness of the service. Another recommendation was for staff to compete individual activity timetables with patients in accordance with best practice for rehabilitation. We found patients had their own individualised timetables in place during the inspection.

Management of risk, issues and performance

The managers used systems to identify, understand, monitor, and reduce or eliminate risks that were mostly effective. They ensured risks were dealt with at the appropriate level. The service had a local risk register which the manager added to. Risks included the management of ligature points and illicit substances. The manager said the top challenge for the service was the environment.

The service had an action plan for planned refurbishment and redecoration works that needed doing. However, some things needed refurbishment immediately. For example, patient bedrooms needed redecorating, refurbishing and new furniture. New flooring was being installed in September 2019. New furniture being installed into patient's bedrooms had a completion date of March 2020. However, specific redecoration of patient bedrooms was not on the action plan. This meant it was not clear when

Long stay or rehabilitation mental health wards for working age adults

Good 

patients would have their rooms re-decorated. Since the inspection the hospital manager has provided assurances that repainting of patient bedrooms will start immediately (5 August 2019).

Information management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The service had a dashboard that held pertinent data about the service, for example, discharges and risk assessment ratings.

The information systems were integrated and secure. The managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Administrative staff supported managers to record key performance indicators.

The service notified the Care Quality Commission of notifiable incidents, including incidents involving the police.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services. Staff could attend the organisation's quarterly staff representative group. A staff representative from the services in the region attended this and discussed with peers what they wanted to improve on. However, at the time of the inspection the group had not met for the last three scheduled meetings. Staff said this was due to lack of

staff attendance as they felt it was ineffective in hearing their suggestions. The provider has since appointed a new staff representative to restart this group and monitor its effectiveness going forward.

Patients and carers had opportunities to give feedback on the service. For example, a patient previously worked as service user representative. In addition, patients gave staff feedback in weekly community meetings and on the service's 'you said, we did' boards.

The managers used the feedback from surveys to make improvements. The patients completed a satisfaction survey in November 2018. The results showed that 75% of patients felt that their overall care at the service was very good. Most patients (92%) felt safe at the service and 54% felt involved in their care and treatment. Staff listened to patients and used their feedback to improve the service.

Patients and carers were involved in decision-making about changes to the service. For example, patients had been involved in recruitment panels to interview prospective new staff.

The service collaborated with partner organisations to help improve services for patients. This included community mental health teams and social workers. This ensured that staff worked with others to ensure consistent care and treatment for patients.

Learning, continuous improvement and innovation

The service did not take part in accreditation schemes. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must continue to implement the refurbishment plans throughout the service and ensure they meet the fire safety standards. In addition, the provider must ensure that patients' bedrooms are refurbished and redecorated within a timely manner to ensure they are safe.

Action the provider **SHOULD** take to improve

- The provider should ensure they manage controlled drugs safely. Controlled drugs must always be kept locked away and follow its own policy about who should hold the controlled drugs keys.
- The provider should ensure staff dispose of medicines stock that has expired.

- The provider should ensure they review their use of blanket restrictions to ensure that they are appropriately applied, based on patients' individual needs and preferences.
- The provider should ensure that all staff know where potential ligature points are throughout the hospital.
- The provider should consider the holistic needs of the patients, by considering their sexuality and cultural needs in a proactive way.
- The provider should ensure they keep patients food stored safely in the fridge and clearly dated and labelled.
- The provider should ensure that patients' bedrooms adequately meet their needs and provide a therapeutic and comfortable environment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider did not provide an environment that was well maintained and clean for patients. Patient bedrooms needed refurbishing and updating to ensure they were fit for purpose and met fire safety standards.