Cygnet Health Care Limited

Cygnet Hospital Godden Green

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Cygnet Hospital Godden Green is an independent hospital providing specialist inpatient Acute and Psychiatric Intensive Care Unit (PICU) services to adult women of working age.

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

The service provided safe care. The ward environments were safe and clean. A housekeeper tended to the wards daily and staff were proactive in repairing or removing anything broken or damaged. Environmental risks were identified and removed or reduced as appropriate.

The wards had enough nurses and doctors. Staff assessed and managed risk well. They managed medicines safely and followed good practice with respect to safeguarding.

The service minimised the use of restrictive practices, with staff making every attempt to avoid using restraint by using de-escalation techniques. The hospital was also training staff in “safewards”. This was an initiative to improve the ward environment, reduce incidents of aggression and improve safety for both patients and staff.

Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. The care plans we saw included detailed inputs from other members of the multidisciplinary team. In addition, patients had Positive Behaviour Support (PBS) plans which were in place to support staff to manage challenging behaviours and ensure appropriate follow up with patients.

They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.

Risk assessments were updated and reviewed more than once a week and considered any changes/ incidents. Full risk screenings were completed frequently. During this inspection we saw evidence of risk being assessed at admission, as well as frequent risk reviews for both increases and decreases in risk and full justifications of these decisions being recorded.

The ward teams had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare. Staff told us that they were dedicated to fostering effective working relationships and communication within the multidisciplinary teams and worked together to address issues. Staff also told us that they maintained contact with external agencies including care co-ordinators, GPs and social workers.

The service held regular multidisciplinary handover and information sharing meetings, with good attendance and significant information shared which enabled them to monitor and discuss patient’s risks and needs, and other issues impacting the service. We observed positive attendance and information sharing at daily board and flash meetings where staff made sure they shared clear information regarding incidents, risks, safeguarding, medication changes and admissions/ discharges.

Summary of findings

Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff knew who their Mental Health Act administrator was and were positive about the support and guidance given by them on both MHA, and MCA. Staff told us that they made sure the service applied the MHA and MCA correctly by completing audits and discussing the findings.

Staff treated patients with compassion and kindness and understood the individual needs of patients. All patients spoke positively of most staff and felt they were respectful, polite and caring. They actively involved patients and relatives/ carers in care decisions. Staff often gave feedback over the phone regarding their relative's care.

The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this. The hospital had contracted block beds on each ward to provide availability to the local NHS trust. We saw that patients on Castle ward were reviewed regularly to ensure their placement remained appropriate. On Oakwood ward, the emphasis was on short term treatment with an expectation that the length of stay would be kept to a minimum.

The service was well led, and the governance processes ensured that ward procedures ran smoothly. Staff were complimentary about the leadership and support provided by the senior management team. Staff told us that there were open lines of communication amongst local level teams and senior managers so that risks were shared and managed well.

However:

There was poor practice on both wards of staff frequently entering the clinic rooms without knocking or identifying whether it was suitable to enter. This challenged patient's privacy and dignity and disrupted staff carrying out clinical activities, such as administering medicines.

We were aware that patients on Oakwood Ward did not have access to their own keys for their bedrooms. This challenged their privacy and the safety of their belongings when they left their rooms unattended. We saw that patients had made complaints relating to losses of their possessions to staff.

Patient care plans and PBS plans had improved since the last inspection. However, there was room for further personalisation to include triggers and interventions that were specific to each patient and described individual de-escalation preferences.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good 	

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Hospital Godden Green

Cygnet Hospital Godden Green is a 27 bed hospital located near Sevenoaks, Kent. Castle ward is a 12 bed psychiatric intensive care unit (PICU) for female patients, and Oakwood ward is a 15 bed acute ward for female patients. At the time of our inspection, there were 11 patients receiving treatment on Castle Ward and 13 patients receiving treatment on Oakwood ward.

The hospital receives referrals from all areas including other acute services and prisons. They provide short term care for women both detained under the Mental Health Act as well as informal patients, those experiencing mental health crisis and those experiencing difficulties that present a risk to the wellbeing of themselves and/ or others. The hospital treats patients with a range of conditions including acute mental illness and co-morbidities. It provides assessments and treatment with the aim of providing a safe and stabilising environment, supporting service users to manage their mental health and return to living independently within the community.

The hospital is preparing to open a further ward, Upper Oakwood Ward, in late October 2021. This aims to be a small and supportive 6 bed female mental health acute service for female patients who have lower level care and treatment needs and who are in the later stages of their care and planning their discharge out of hospital. We will return to inspect this ward in due course.

The hospital is registered 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.

A hospital manager has recently been appointed full time at the service and had applied to be registered with the Care Quality Commission as the registered manager. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations.

Cygnet Hospital Godden Green was last inspected on 10 November 2020. This was an inspection of the PICU Castle ward, as Oakwood ward was not open at the time. Following previous inspections at the hospital in September and October of 2020 the provider made the decision to close its Child and Adolescent Mental Health Service (CAMHS) wards at this location.

At our last inspection we told the provider that they must take action to improve the following:

- The provider must ensure that staff only use physical interventions as a last resort and only following the use of de-escalation techniques.
- The provider must ensure that patients have adequate access to toilet paper.
- The provider must ensure personal evacuation plans are individualised and contain information relevant to assisting the patient to leave the ward during an emergency.
- The provider must ensure that all risks are identified on their environmental and fixed ligature point assessments, that staff are aware of the risks and know how to mitigate the risk.
- The provider must ensure that potentially dangerous items are always stored securely.
- The provider must ensure staff re-assess and rate risk regularly to reduce un-necessary restriction on patients.

Summary of this inspection

- The provider must ensure patients are able to make private phone calls either on their personal mobile phone or via ward phones.
- The provider must ensure staff knock and wait before entering patients' bedrooms, unless it is an emergency.
- The provider must ensure patients have enough space to store their personal belongings within their bedrooms.

At this inspection we found that the provider had made improvements and had addressed the majority of concerns highlighted to them in the previous inspection report.

What people who use the service say:

Patients told us that the environment was clean and comfortable. They told us that a housekeeper attended the wards daily and that anything broken or damaged was removed or repaired quickly. Patients told us that they were able to keep personal items in their bedrooms, if assessed as safe to do so. If not, personal items were locked away in the office.

Patients said that they were able to use their mobile phones in their bedrooms and had access to a ward tablet with supervision.

Patients told us that they felt safe and that staff were always proactive when anything happened on the wards. Some patients who had been restrained told us that they had been debriefed afterwards.

Patients said that there had not been any staff shortages and that they never had issues with taking leave or attending therapies/ activities. They told us that staff were present on the wards and available to help.

Patients told us that they had been able to raise issues with staff and were able to give feedback about the service and make suggestions on improvements in both community meetings and patient forums.

All patients spoke positively of most staff and felt they were respectful, polite and caring. They said that they always knocked on their bedroom doors before entering. Patients also told us that the staff took the time to engage with them and explain things to them.

Patients said they were involved in their care decisions and three patients told us that their family members were involved in their care. One patient also told us that they had an advocate.

Patients were very positive about the food available and said that there was plenty of choice with kitchen staff accommodating requests and any dietary requirements. Patients told us that they have snacks and drinks available outside of mealtimes.

Patients told us that they really enjoyed the variety of activities available.

How we carried out this inspection

The team that inspected the hospital comprised of one CQC inspection manager, three CQC inspectors, one specialist advisor, and one expert by experience (remotely). The expert by experience had lived experience of mental health services and detention under the Mental Health Act.

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

Summary of this inspection

During the inspection visit, the inspection team:

- Undertook a tour of both Castle and Oakwood wards including the seclusion room.
- Looked at six care plans and risk assessments for each ward.
- Looked at prescription charts and clinic rooms on both wards.
- Attended and observed meetings including a daily board meeting for each ward, the hospital's daily flash meeting, Head of Departments meeting and the weekly community meeting on Castle Ward.
- We spoke with 20 members of staff including nurses, a clinical psychologist, assistant psychologists, healthcare assistants, resident medical officer, an occupational therapy assistant, activity coordinator, ward manager, deputy ward managers, consultant and clinical audit lead, medical director, safeguarding and wellbeing lead, head of psychology, support services manager, clinical services manager, and hospital manager.
- We spoke with six patients.
- We spoke with three carer/relatives.
- We reviewed a range of policies, procedures and other documents relating to the running of the service.

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

Areas for improvement

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

Action the service MUST take to improve:

- The provider must ensure that the clinic rooms are only entered by staff requiring to use them for their purpose, and that staff knock and wait for permission to enter, to protect patient's privacy, and avoid un-necessary interruption to colleagues carrying out clinical duties. (Regulation 10(1): Dignity and Respect)
- The service must ensure that patients, where assessed as safe to do so, are given keys to their bedrooms to allow them privacy, and to protect their belongings. (Regulation 10(1): Dignity and Respect)

Action the service SHOULD take to improve:

- The service should continue work to improve PBS plans by personalising them to identify specific triggers and effective de-escalation interventions tailored to each patient.

Our findings

Overview of ratings

Our ratings for this location are:

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

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

Good

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

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

Good

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

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff could observe patients in all parts of the wards although they were seeking to relocate the nurse's office in Castle ward. This was due to concerns around reduced visibility of the communal kitchen area when patients congregated in the space outside of the current nurse's office.

Each ward had a ligature audit with an attached heat map identifying risks in each area of the wards. The ward manager and hospital managers had recently reviewed the ligature audit action plans and these included appropriate mitigation for high risk areas where patients would only have access under staff supervision. Ligature risk assessments were carried out yearly by ward managers and maintenance.

Staff had easy access to personal alarms and patients had easy access to nurse call systems, all of which were checked frequently.

Maintenance, cleanliness and infection control

All ward areas were clean, well maintained, well-furnished and fit for purpose. Patients told us that a housekeeper attended the wards daily and that anything broken or damaged was removed or repaired quickly. We observed environmental issues being discussed at the daily flash meeting and actions taken for maintenance where necessary.

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

Good

Managers told us that COVID was still a significant risk for the hospital. Most staff followed infection control policy, including handwashing. However, we did observe some staff wearing their face masks incorrectly. This was raised at the time of the inspection. It had been recognised by senior management in the flash meeting who advised that all staff were to be reminded to adhere to the mask wearing policy.

We saw that the hospital had a robust screening and management plan of new admissions and COVID19 positive patients. This included isolating newly admitted patients in bedrooms at the end of the wards to minimise potential spread of COVID19. In addition, testing of all patients was required, 72 hours prior to admission, if possible, and repeated on admission. Where testing was not possible, decisions were made around necessary isolation. Staff were also required to carry out lateral flow tests twice a week.

Seclusion room

The hospital had use of one seclusion room on Castle ward which allowed clear observation and two-way communication via a working intercom. It had a toilet and a clock/ calendar which was visible to patients. It was clean and tidy, with suitable bed and bathroom areas and CCTV and mirrors ensured staff observation at all times. The lighting and temperature were appropriate and could be controlled by staff. Staff told us that if a patient on Oakwood ward required seclusion, they were able to use this room. There was however a quiet room with bean bags on Oakwood ward which was designed to be used by staff when patients needed time out or space to be deescalated.

Clinic room and equipment

There were clinic rooms on both wards. Clinic rooms were clean, fully equipped, with accessible resuscitation equipment and emergency drugs. Emergency equipment was checked daily and there was also a weekly resus checklist carried out. An audit of these checks was carried out weekly.

However, we observed poor custom and practice with regards to the clinic rooms on both wards; with several staff entering in and out of this room on a recurrent basis without knocking beforehand or identifying whether it was suitable to enter. This not only challenged patient's privacy and dignity whilst they were in the clinic room, but it also disrupted staff carrying out professional duties safely, especially administering medication.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. Patients and staff told us that there were no concerns around staffing numbers and that where necessary, ward managers and consultants assisted on the ward floor.

Nursing staff

The service had enough nursing and support staff to keep patients safe. The service had reducing vacancy rates, with five healthcare assistant and two registered nurse vacancies across both wards. They were also actively recruiting four registered nurses and six healthcare assistants in preparation for opening the new Upper Oakwood Ward. Managers told us that they had an ongoing recruitment plan in place to fill these vacancies, including increased payment incentives.

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

Good

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift, with agency workers given six month contracts with the intention of being made permanent following this. The hospital had 14 agency staff attending the next induction.

The service had a staff turnover rate of 61%. Staff told us that this was largely due to the number of staff who left when the previous CAMHS service was closed. Managers were focused on ensuring they retained their current staff, as well as recruitment.

A staffing matrix was used indicating the staffing required depending on the number of patients on the wards. The ward manager told us that they could adjust staffing levels according to the needs of the patient's acuity and risk, and where if more patients are on enhanced observations, more staff would be scheduled. There were no patients on enhanced observations at the time of inspection.

Patients had regular one to one sessions with their named nurse which we saw evidence of in their care plans. Patients that we spoke to told us that they never had their escorted leave or activities cancelled. Staff told us that if a patient had planned leave cancelled, this is recorded as an incident.

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. They had two hospital consultants, a ward doctor on each ward and a registered medical officer for the hospital.

Mandatory training

Most staff had completed and kept up-to-date with their mandatory training, with 83% of staff overall having completed this. The shortfalls in completion were observed to be mostly doctors and psychology staff. The mandatory training programme was comprehensive and met the needs of patients and staff. Ninety-three per cent of staff had also completed statutory training. The statutory training was wide-ranging and included Prevention and Management of Violence and Aggression (PMVA), Infection Prevention and Control, and Equality and Diversity. Managers told us that their system notifies managers when people are due for mandatory and statutory training. It was the responsibility of the ward manager to check this and book in staff for training. Training was delivered both via e-learning and face to face.

Assessing and managing risk to patients and staff

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

Assessment of patient risk

At the last inspection in 2020, we told the provider they must ensure staff re-assess and rate risk regularly to reduce un-necessary restriction on patients. During this inspection we saw evidence of risk being assessed at admission, as well as frequent risk reviews for both increases and decreases in risk and full justifications of these decisions being recorded. Staff told us that risk assessments were reviewed every morning by the psychology team who considered any incidents. Staff used a Cygnet wide in-house risk assessment tool to carry out these assessments.

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

Good

The hospital had procedures in place to manage risk appropriately according to the presenting risks of individual patients. Staff gave examples of individual risk assessments that were carried out including the possession of personal items, toilet roll, refusal of food, access and use of mobile phones, and substance misuse concerns, with contingency actions to manage this appropriately recorded in the patients care plan.

Management of patient risk

Staff knew about risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients. We saw evidence of appropriate action being taken following incidents and staff updated in board and flash meetings. All enhanced observations in place for seven days or more were reviewed by the clinical services manager and medical director. All enhanced observations over 21 days were reviewed by members of the senior management team.

Staff had access to CCTV of all areas of the ward areas and mirrors aided sight in patients' bedrooms for observations. Staff told us that when carrying out observations at night they used red light torches to avoid waking patients up. This was put in place following feedback from patients.

Staff felt that the risk and needs of the patients were suitable for the wards. Multidisciplinary teams reviewed the admission paperwork before accepting new referrals and always considered the current acuity and presenting risks of the ward. Staff advised us that they stayed strict with their admissions criteria but had less control over the admissions from a local NHS trust due to the contract block beds they have on both wards. However, they did ensure that they had enough clinical information to be able to assess suitability and had mechanisms and relationships in place to be able to push back any inappropriate referrals.

Use of restrictive interventions

Between June and August 2021, Oakwood ward had an average of 13 restraints per month and Castle ward had an average of 23 restraints per month recorded. At the last inspection in 2020, we told the provider that they must ensure that staff only use physical interventions as a last resort and only following the use of de-escalation techniques. We saw evidence that staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

All staff we spoke to explained how de-escalation and restraint review processes were embedded as standard practice now to ensure staff were taking the time to de-escalate appropriately prior to use of physical restraint or seclusion. Restraint incidents meeting the serious incident/ safeguarding threshold were reviewed by the safeguarding lead and psychology team, and the clinical services manager reviewed five incidents monthly from each ward. Staff were offered reflective practice and debriefs after all incidents, particularly if de-escalation was not witnessed. This encouraged learning and ensured their understanding of the patient's PBS plan. PBS plans were used to assist staff in managing triggers to challenging behaviour in aim of reducing the need for restrictive interventions.

At the time of the inspection, the hospital had advised that they were training staff in "safewards" with the aim of rolling this out by the end of October. This was an initiative to improve the ward environment, reduce incidents of aggression and improve safety for both patients and staff. In addition, the clinical audit lead had conducted a recent audit on practice of positive and proactive care to reduce physical restraints which had been carried out from a patient's perspective. This had concluded that patients were given appropriate 1:1 debriefs following restraint and that they felt there had been good practice of de-escalation methods used to calm patients before the physical restraints used.

When a patient was placed in seclusion, we saw evidence that staff kept clear records.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff kept up-to-date with their safeguarding training. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The hospital had a safeguarding lead who monitored and reviewed all safeguarding incidents daily. These were recorded on a safeguarding tracker, as well as electronic recording systems. All staff we spoke to identified how safeguarding incidents were recorded, escalated and reviewed as per protocol and all were aware of how to make safeguarding referrals. The safeguarding lead had regular contact with both police and the local authority to discuss concerns and incidents, and worked closely with the advocate to update on any incidents.

Staff access to essential information

We observed that patients had both paper-based and electronic records, all of which were stored securely and kept up to date. Whilst patient notes were comprehensive, some staff were not able to access the electronic recording systems easily. Staff told us that some of the systems were not straightforward to navigate and sometimes information was saved in different places which made it difficult to triangulate. Management recognised this issue and told us that they were looking at purchasing a new IT package to improve this.

Medicines management

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

We reviewed six prescription charts on each ward, all of which were signed and dated. Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medical staff reviewed patients' medicines weekly or based upon presenting mental health state and physical health concerns. They provided specific advice to patients and carers about their medicines. Staff told us that they had a side effect monitoring chart and that they also developed medication information leaflets for patients. Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff carried out daily error checks in ward rounds and used National Institute of Clinical Excellence (NICE) guidelines as part of their ethical approach to treatment. We saw evidence that the service had systems to ensure staff knew about safety alerts, such as allergies, so patients received their medicines safety. Staff told us that audits were carried out based on the Screening Tool of Older Persons' Prescriptions (STOPP) which is a NICE recommended tool for clinicians to review potentially inappropriate medications in older adults. The consultants used this to check how frequently unscheduled medication is used to ensure this was not excessive or inappropriate in controlling patient's behaviour. An external clinical pharmacy service was used to ensure the safe and effective use of medicines.

Reporting incidents and learning from when things go wrong

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

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

Good

At the last inspection, we told the provider that they should ensure that all incidents were correctly categorised. All incident records were now checked and signed off by the ward managers to ensure these were correctly categorised and these were further reviewed by the clinical services manager at the daily flash meeting.

Managers shared learning about incidents occurring both in the hospital and other Cygnet wide Health Care sites. They published a "lessons learnt" newsletter to staff which identifies incidents, learning and action to be taken. They also discussed learning from incidents regularly at internal meetings.

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

Good

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs and were holistic and recovery-oriented.

We saw evidence of comprehensive care plans on both wards which were regularly reviewed and updated when a patient's needs, or risks, changed. The care plans we saw were holistic and included detailed inputs from other members of the multidisciplinary team. In addition, patients had PBS plans which were in place to support staff to manage challenging behaviours and ensure appropriate follow up with patients.

However, whilst we saw care plans and PBS had improved, they still lacked specific detail of triggers and effective interventions for the individual patient, particularly around de-escalation. We felt that these could be improved further by being more specific, person centred and individualised by stipulating the de-escalation techniques used and identifying what the patient felt was helpful and what they would prefer done in potential future occurrences. Staff recognised that they needed more patient involvement and had plans in place for this.

Staff told us that patients were seen and assessed for both their mental and physical health needs within 72 hours of admission and we saw evidence of this and regular reviews within care plans.

We saw evidence that care plans were recovery-orientated with discharge planning recorded throughout. Staff told us that they plan discharge from admission in order to make plans outcome orientated.

Best practice in treatment and care

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

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

Good

The hospital had access to a contracted psychology team, activity coordinators, and occupational therapists. The hospital ran activity timetables on both wards seven days a week, 8am- 8pm. This included a breakfast group, movie nights, beauty time, karaoke, baking, and arts/ crafts. In addition, psychological therapies were offered five days a week and included both 1:1 and group psychology sessions on Castle ward, and CBT, anger management and DBT on Oakwood ward. The service also had a personal trainer who facilitated additional activities for the patients, such as gym and exercise classes. Staff told us that they personalise the timetables for more complex patients and patients told us that they really enjoyed the variety of activities available.

We saw evidence that physical observations were being completed by nurses daily and physical health care needs were identified and monitored appropriately. National early warning score (NEWS2) charts were being monitored daily. Staff told us that doctors were available on wards at all times and completed weekly rounds as standard, as well as any additional physical health care when required.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients told us that they were supported with healthy eating and smoking cessation.

Skilled staff to deliver care

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

The service had a full range of specialists to meet the needs of the patients on the ward. Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work. Staff told us that they had a two-week induction, and this was in place for both permanent and agency staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that they could ask for additional training and were engaged in regular reflective practice to discuss issues and share experiences for improved knowledge and development.

Managers supported permanent medical and non-medical staff to develop through regular, constructive appraisals and clinical supervision of their work. We saw evidence across both wards, that the service monitored appraisals and clinical supervision, and this was discussed at clinical governance meetings.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We viewed comprehensive minutes from both service level clinical governance meetings and daily flash meetings.

Multi-disciplinary and interagency teamwork

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

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

Good

Patients were supported by a team of staff from a range of disciplines who worked well together to ensure care was delivered and outcomes achieved in line with care and discharge plans. Staff held daily multidisciplinary meetings to discuss patients which enabled them to monitor and discuss any potential changes or follow ups needed to patient's care. We observed positive attendance and information sharing at daily board and flash meetings where staff made sure they shared clear information regarding incidents, risks, safeguarding, medication changes and admissions/ discharges.

Staff told us that they were dedicated to fostering effective working relationships and communication within the multidisciplinary teams and worked together to address issues. Staff also told us that they maintained contact with external agencies including care co-ordinators, GPs and social workers, who were invited to ward reviews and meetings, if appropriate. Staff did advise of issues registering patients temporarily with local GPs and they were exploring the option of having a visiting GP for the hospital. In addition, the hospital's safeguarding lead had effective working relationships with both local authority and police and held weekly and monthly meetings to discuss current safeguarding concerns.

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

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice. Staff knew who their Mental Health Act administrator was and were positive about the support and guidance given by them on both MHA, and MCA. Staff told us that they made sure the service applied the MHA and MCA correctly by completing audits and discussing the findings.

Staff told us that they would always ensure they explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We also saw evidence of information documents on patients' rights available in communal areas for both informal and detained patients.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. We saw evidence in care plans of staff requesting an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

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

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act although one member of staff we spoke to was not able to advise of the five principles when asked. Training was on offer to staff to aid their understanding and staff told us that they would speak to the ward manager and other staff if they had concerns around capacity.

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

Good

We saw evidence of capacity and consent recorded in care plans, with capacity to consent to treatment obtained at admission and evidence of this being regularly reviewed. We also saw evidence in care plans of staff attempting to support and engage patients in decision processes before deciding that a patient did not have the capacity to do so. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff told us that they held a best interest meeting which would involve the patient, the nursing team, the consultant(s) and the patient's next of kin.

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

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet and respectful when caring for patients. Patients told us that staff always knocked on their bedroom door or called out before entering. We saw labels on the door which allowed patients to indicate their preferences with regards to staff (male/female) and how they wished to be roused.

Patients told us that staff were kind, compassionate, and caring. During the inspection, we observed staff being warm and responsive when engaging with patients. Staff understood and respected the individual needs of each patient and supported patients to understand and manage their own care treatment or condition.

Patients told us that staff took the time to engage with them and explain things. One patient also showed us how staff had provided her with an individual whiteboard and large sheets of paper which helped her to write her thoughts down and attach these on her wall; this assisted in her risk management and prevented her from escalating behaviour when prohibited from writing on the walls.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff told us that all patients have an initial introduction to the ward and are taken to meet other patients. They are also introduced at the next available community meeting. Patients also received a decorative 'welcome box' which included comfort and personal hygiene items such as toothpaste, toothbrush, sweets, shower gel, hot chocolate, flannel, deodorant. Staff told us that feedback from patients had been that this gesture made them feel cared for.

Patients could give feedback on the service and their treatment and staff supported them to do this. The hospital held weekly community meetings which gave patients the opportunity to provide feedback and raise issues. In the

community meeting we observed, they had also set up a people's council and elected two patient representatives. A patient told us that they could use these forums to suggest improvements and we observed patients raising issues with sanitary disposal bins and toilet roll holders which were subsequently escalated to the senior leadership team at the next flash meeting. Oakwood ward also had informal feedback sheets which patients could use to feedback outside of the meeting forums. Staff told us that their drive to recruit more female staff was requested by patients.

Staff made sure patients could access advocacy services. Patients had easy access to information and contact details of the independent mental health advocate (IMHA) which was displayed clearly on posters in the main communal areas of the hospital. The advocate attended the service twice a week, visiting each ward for one day.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers, where they had consent to share the information. Staff told us that the involvement of relatives/ carers was a priority. Staff often gave feedback over the phone regarding their relative's care and we saw evidence of relatives/ carers being communicated with in care plans.

Patients told us that their relatives/ carers were involved and updated about their care. One of the relatives/ carers that we spoke to advised that the hospital had gone to great lengths to ensure they understood what was going on with their relative. However, the relatives/ carers we spoke to had advised of language barriers with staff which affected their understanding when receiving updates on their relative's care.

Staff helped families to give feedback on the service with dedicated carer support leads and specific ward carer support leads. They also provided additional advice and support to families with the psychology team offering psychoeducational sessions and signposting to community support. The hospital also provided a carers support newsletter and carers events including a summer BBQ and a Christmas party to promote interaction and enable them to be kept updated with the service.

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

Requires Improvement

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

Access and discharge

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. We

saw that patients on Castle ward were reviewed regularly to ensure their placement remained appropriate. On Oakwood ward, the emphasis was on short term treatment with an expectation that the length of stay would be kept to a minimum. All admissions on Oakwood ward were given an estimated discharge date at the first ward round and decisions around discharges or transfers were made with the involvement of hospital staff, care coordinators, patients and their families to support on-going treatment and effective pathways.

Discharge and transfers of care

Managers monitored the number of patients who experienced a delayed discharge and these were reported to Kent safeguarding teams when they occurred. Managers told us that the common issues with delayed discharges were factors outside of the service, including funding and availability of local beds. We reviewed the discharge and transfer policy for the hospital which sets out clearly how discharges and transfers of patients were managed at a local level. The emphasis on both wards was that a patients discharge planning is considered at the point of admission. On Castle ward, patients were usually transferred to an appropriate inpatient service which could take place both internally, if appropriate, or externally. The service encouraged effective working links with the referring service to support on-going treatment and pathways, considering the involvement and safe conveyance of the patient throughout these decisions.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment and dignity. Each patient had their own bedroom with an en-suite bathroom and there were quiet areas for privacy. Patients could personalise their bedrooms with posters or drawings placed onto the walls. Patients had enough room in their bedrooms to store personal items if it was appropriate and safe to do so. Patients told us that if not, other personal items were locked away in the office.

However, we were aware that patients on Oakwood Ward did not have access to their own keys for their bedrooms. We felt that this challenged their privacy and the safety of their belongings when they left their rooms unattended. Additionally, this also brought about security concerns as there had also been a theme within patient complaints to staff around lost property making the impact of this greater. We raised this to the provider at the time of the inspection and the provider took immediate action and now all patients, where risk assessed, had bedroom keys.

Additionally, whilst we saw evidence of staff being respectful of patient's privacy most of the time, staff's behaviour when entering the clinic rooms on both wards was a risk to patient's privacy and dignity, and also to the concentration of staff carrying out clinical duties. We observed several staff entering the room without knocking or establishing if it was suitable to enter. This happened at a high frequency with staff entering the clinic room up to ten times in one hour, and also whilst a patient was undergoing a physical examination. We shared this observation with the provider at the time of inspection.

Staff used a full range of rooms and equipment to support treatment and care. Staff told us that they would always engage with patients wherever they felt most comfortable, whether this was their bedrooms, communal areas, or one of the private rooms. The service had quiet areas and a room where patients could meet with visitors in private. The patients we spoke to told us that they had access to their mobile phone which they could use privately in their bedrooms. Additionally, staff told us that they had cordless ward phones which patients could take to their bedrooms to use. Phone use was risk assessed and a logbook kept of ward handsets to monitor these. Patients were also given access to the hospital wireless internet if they had an internet enabled phone.

Both wards had access to outdoor space. Oakwood ward was unlocked and accessible freely for all patients throughout the day, with those approved for Section 17 leave able to access further areas of the hospital grounds. However, Castle

Ward required staff to chaperone patients to the outdoor courtyard, or outside of the building if they were approved for Section 17 leave. This was due to the security of the ward and the necessity for staff to enable the access to and from the outdoor spaces. Also, the courtyard used by Castle Ward was not accessed after dark which impacted the patient's ability to access outside space in the winter evenings.

Patients could make their own hot drinks and snacks and were not dependent on staff. The service offered a variety of good quality food. Patients were very positive about the food available and said that there was plenty of choice with kitchen staff accommodating requests and any dietary requirements. Patients told us that they had snacks including bread, biscuits and cereals, as well as drinks, available outside of meal times.

Patients' engagement with the wider community

Staff helped patients to stay in contact with families and carers. Staff told us that families were encouraged to attend ward rounds and have frequent contact which could be facilitated via video conference. They also had a visiting room available.

Meeting the needs of all people who use the service

The service met the needs of all patients. Staff helped patients with communication, advocacy and cultural and spiritual support. The service could support and make adjustments for those with communication needs, including translation and interpreter services, or any other specific needs. They operated within the Cygnet policy around equality and diversity, underpinned by the principles of both the Equality Act (2010) and the Human Rights Act (1998).

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients told us that kitchen staff catered for dietary requirements or allergies, and we saw that patients had a food management record which had vegetarian/vegan and halal/ kosher options.

Patients had access to spiritual, religious and cultural support. The service had multifaith rooms on both wards. Staff told us that they always upheld respect of patient's cultural and religious needs.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas and provided contact details for relatives/ carers within carer support newsletters. Patients had access to feedback slips if they wished to complain or raise concerns anonymously. They had recorded six complaints in the last three months.

We reviewed four complaints and saw evidence of appropriate action taken as a result. Patients received feedback from managers after the investigation into their complaint. "Lessons learnt" feedback was shared with the wider hospital team via a regular newsletter and staff told us that Cygnet also share learning experiences from other hospitals.

The service provided patients compliments forms and we observed compliments being celebrated and shared in a community meeting.

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

Good

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

Good

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed, were visible in the service and approachable for patients and staff. Staff were complimentary about the leadership and support provided by the senior management team. We found that the hospital manager was proactive and keen to empower staff and make them feel valued, with recognition of what factors had previously resulted in low morale within the service. They had introduced shining star nominations in aim of recognising positive work from staff.

Vision and strategy

Staff knew and understood the provider's vision and values. Staff we spoke to told us that they were excited about the direction of the hospital and felt that changes were being implemented for the better. They told us that patient focused care and implementing safe wards was the vision for the service, as well as working as a team to improve the hospital and ensure safe and quality care for patients. The hospital was seeking to offer an Occupational Therapist apprenticeship alongside universities.

Culture

Staff felt respected, supported and valued and staff we spoke to said that the service was a positive place to work. They told us that the service provided opportunities for development and career progression. We saw evidence of staff members being promoted to more senior roles within the service. Staff also told us that they provided flexible working agreements. Management told us that a lot of work is being done around improving the positive culture of the hospital, and that staff were receptive to the changes.

Staff told us that they felt listened to and able to raise concerns without fear. The service had a number of resources available for staff to provide feedback.

Governance

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

Managing risks, issues and performance

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

Good

The service had an overall risk register, which covered high risk areas of the hospital and described mitigations to manage the risks. Incidents, safeguarding and complaints were appropriately logged and investigated. Various audits were also in place at ward level and learning had been taken from these audits. They maintained a six-monthly tracker of clinical audits. Managers told us that they had recently carried out an audit on incident times to identify when these occurred most frequently. From this audit they recognised that these increased on weekends and evenings when there were less provisions from occupational therapy and where patients were more likely to experience boredom. As such, they told us that the service was now looking to increase this provision. They also had outcome scale audits for patients which were assessed on admission and reviewed on discharge to monitor whether these had been achieved.

Managing information

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Managers told us that the service was seeking to obtain accreditation through Accreditation for Inpatient Mental Health Services (AIMS) which recognises high standards of organisation and care, and National Association of Psychiatric Intensive Care (NAPICU) which is an organisation dedicated to improving service user experience and promoting staff support. In addition, they benchmarked their restraint data against other PICUs within the Southeast to monitor their own performance.

Learning, continuous improvement and innovation

Staff told us that the ward managers had a rota of a “monthly walkabout” where the ward managers go onto the other ward in order to peer review and share learning and good practice.

Engagement

Staff were able to provide feedback in a number of ways. This included a yearly staff survey, a staff relations group meeting which was chaired by a staff member who fed back to senior management, Freedom to Speak Up guardians who staff could confidently discuss issues with and the hospital’s wellbeing lead who sought staff feedback regularly and updated on this at daily flash meetings, weekly Head of Department Meetings and monthly clinical governance meetings. They also displayed posters around the service with information of an independent whistleblowing contact.

Patient feedback was captured at the ward community meetings and the patient's council. At discharge, staff offered patients a feedback survey. Staff actively sought the views of carers via carers leads and a friends and family survey.

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 10 HSCA (RA) Regulations 2014 Dignity and respect • There was poor practice on both wards of staff frequently entering the clinic rooms without knocking or identifying whether it was suitable to enter. This challenged patient's privacy and dignity and disrupted staff carrying out clinical activities, such as administering medicines. (Regulation 10(1): Dignity and Respect) • We were aware that patients on Oakwood Ward did not have access to their own keys for their bedrooms. This challenged their privacy and the safety of their belongings when they left their rooms unattended. We saw that patients had made complaints relating to losses of their possessions to staff. (Regulation 10(1): Dignity and Respect)