Cygnet Health Care Limited

Cygnet Lodge Kenton

Inspection report

74 Kenton Road
Kenton
HA3 8AE
Tel: 02089070770
www.cygnethealth.co.uk

Date of inspection visit: 31 March 2022, 7 April 2022
Date of publication: 20/07/2022

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	Requires Improvement
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location went down. We rated it as requires improvement because:

- At this inspection we rated this service as requires improvement overall and inadequate for safe.
- Forms used to record patients' vital signs did not support staff to identify when they needed to escalate findings. Staff did not always record when early warning signs were elevated in the patient electronic record, or record what action had been taken in response. Staff we spoke with did not know the escalation procedure for elevated scores. Patient care records did not always highlight risks from specific medications such as the risk of constipation from Clozapine, which meant this risk was not assessed or monitored consistently. Staff did not regularly monitor side-effects of medicines experienced by patients.
- Staff did not always record observations of patients in line with the provider's policy. Intermittent observations were recorded at regular and predictable intervals. There was a risk that the patients would know when observations would take place and they could plan their actions around this.
- Staff did not always discharge their responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 in a timely way. Patients detained under the Mental Health Act did not always have their rights explained to them as often as required by the provider's policy. We found three patients where there were delays in seeking a second opinion appointed doctor and the service relied on Section 62 of the Mental Health Act, which should only be used for urgent treatment, for several months.
- The service did not deploy sufficient registered nurses on night shifts in line with the provider's staffing matrix and decisions in respect of safe staffing levels.
- Medicines were not always stored and managed well. For example, we found tablets that had been cut into quarters rather than attempts being made to source tablets of a smaller dose. A strip of tablets had been cut in such a way that the expiry date was no longer visible.
- Staff did not always know how to escalate a safeguarding concern to the local authority safeguarding team, and the correct escalation process during a night or weekend shift
- Some clinic room equipment was out of date. Yellow topped blood bottles in the phlebotomy equipment had expired in December 2021. The clinic room was too small for patients to use to self-administer medication, we saw a patient self-medicate in the corridor.
- The governance systems that were in place were not always effective at identifying concerns within the service. Concerns affecting the safety of patients were not identified or overlooked and patients were not always protected from the risk of avoidable harm.
- Patient information was stored both electronically and on paper, and across different systems. This meant that some patient care information was duplicated, whilst there were also gaps and care records were not holistic.
- The service was not proactive in promoting smoking cessation and supported patients to smoke outside the service. One patient was using nicotine replacement therapy at the time of inspection.
- The furnishings were dated, the patient bedrooms were cluttered, and some had curtains falling of the railings.

However:

- The ward environments were clean. The level of serious incidents was low.
- The service had access to medical staff during the day and during night and weekend shifts, or in an emergency.
- Staff assessed patients' mental and physical health upon or soon after admission to the service as required. Risk assessments were up to date.
- The service included the full range of specialists required to meet the needs of patients. Managers ensured that these staff received training, supervision and appraisal. The staff worked well together as a multidisciplinary team.

Summary of findings

- Staff spoke highly of the registered manager and the service culture. Patients said they found staff kind and respectful and they enjoyed being in the service.
- The service provided a variety of occupational therapy led activities and therapies that patients enjoyed. This included opportunities to exercise and volunteer in the community, and group learning and activities onsite as part of a programme of rehabilitation.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement 	Our rating of this service went down. We rated it as requires improvement. Please see the overall summary for further details.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Lodge Kenton

Cygnet Lodge Kenton is registered with the CQC as an independent mental health hospital. The service provides assessment and treatment of patients including those detained under the Mental Health Act.

Cygnet Lodge Kenton is a rehabilitation unit for adult female patients with a diagnosis of mental illness. Mental health commissioners from across the country refer patients to the service. The service aims to provide a care pathway for patients who have been in hospital for some time and require support to prepare for community living. The average length of stay for patients is about 18 months.

CQC last inspected the service in February 2016. We rated the service Good on each of the key questions and Good overall. The service has a registered manager who has been in post since 2019 and is responsible for ensuring the service complies with health and social care regulations. At the time of the inspection there were 15 patients using the service. All patients were detained under the Mental Health Act 1983.

The service is registered to provide the regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

What people who use the service say

We spoke to seven patients and most of the feedback was very positive. Patients told us what they most liked about the service was the kindness and support of the staff. The enjoyed the variety of activities including the recreational activities such as singing and dancing. Patients told us they felt safe in the service. Patients were able to give feedback and request improvements for the service and themselves such as different games. They said the staff were approachable and willing to help. Patients knew about their care plans and enjoyed the therapies. Patients said they were able to take leave after the pandemic lockdown had lifted. Patients said they liked the food and made heathier food choices with the encouragement of staff. Patients told us they were able to stay in touch with their loved ones and attend community meetings.

How we carried out this inspection

During the inspection, the inspection team:

- conducted a review of the environment of the ward and clinic room
- spoke to the registered manager of the service
- spoke with ten staff including three registered nurses, a student nurse, three support staff, an assistant psychologist, an occupational therapist and the consultant psychiatrist
- spoke with seven patients and two carers
- observed a daily planning meeting
- reviewed six medicine administration records
- looked at a range of policies, procedures and other documents relating to the operation of the service

Summary of this inspection

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.

Outstanding practice

No areas of outstanding practice identified

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 staff understand when to escalate physical health concerns and follow up and clearly document actions taken in response to elevated early warning signs. (Regulation 12(2)(b))
- The provider must ensure staff monitor and record side effects from medication used by patients, such as the risk of constipation from Clozapine. (Regulation 12(2)(a)(b))
- The provider must ensure that staff undertake intermittent observations of patients in line with the provider's observation and engagement policy and that staff record these observations accurately. (Regulation 12(2)(b))
- The provider must ensure there are enough registered nurses deployed on night shifts in line with the provider's staffing matrix. (Regulation 18(1))
- The provider must ensure that medicines are managed and stored appropriately so that expiry dates are clearly visible, and the integrity of tablets is maintained by not cutting tablets into inappropriately smaller pieces. (Regulation 12(2)(g))
- The provider must ensure that staff provide clear information to detained patients on a regular basis, in line with the provider's policy, to meet each patient's need to understand their rights under the Mental Health Act 1983. (Regulation 12(2)(b))
- The provider must ensure that where a second opinion appointed doctor is required, the request is made promptly. (Regulation 12(2)(b))
- The provider should implement a cohesive care record system so there is less potential for duplication and/or gaps in care. (Regulation 17(1)(2))
- The provider must ensure there is an effective system in place to assess, monitor and improve the quality and safety of the service. (Regulation 17(1)(2))

Action the service SHOULD take to improve:

- The provider should continue work to actively promote smoking cessation, as it moves towards becoming a smoke free environment.
- The provider should ensure staff know how to escalate a safeguarding to the local authority safeguarding team.
- The provider should ensure blood bottles used for samples are within the expiry date
- The provider should ensure furnishings are fit for purpose

Our findings

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

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

Inadequate

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

Safe and clean environment

The unit was safe and visibly clean. However, some equipment was out of date.

Safety of the ward layout

Staff completed an annual environmental risk assessment. Staff were not able to observe patients in all parts of the unit as the rooms were split over three levels. The service mitigated this risk to patients by admitting low risk patients and adjusting their level of observations of the patients according to the patient risk assessments. Staff were trained in relational security as a way of managing risks arising from the ward layout. Staff were deployed throughout the premises. Staff completed additional security checks twice daily.

The provider undertook an annual ligature audit. The last audit was completed in February 2022 and included pictures of the ligature risks identified. Ligature cutters were kept in the office and clinic room, and in the grab bag which was located in the clinic room. The provider's risk assessment in relation to the premises set out how ligature risks, including those from taps, bannisters and windows were mitigated by staff regularly reviewing and managing risks to individual patients. The service admitted patients who presented a low risk in terms of self-harm. Staff maintained hourly general observations as a minimum for all patients. Staff were placed on a particular floor in order to monitor patients if they were considered a risk.

The service mitigated ligature risks using observations and closed-circuit television (CCTV). The CCTV covered communal areas such as the lounge and the hallways. There was a bedroom close to the nurse's office that a patient could be moved to if their risks increased.

The service undertook a fire drill at least twice a year. The most recent fire drill took place in March 2022. The clinical team lead assessed this fire drill as effective regarding patient safety, time taken, and procedures followed. The recommendations from this drill were that more drills were needed, further staff training on evacuation and managing the fire control panel and obtaining two-way radios for staff. The service planned to have fire drills every three months in future.

There was a back garden that patients had access to. However, the door to this was kept locked. Staff said this was because there was a low fence around the garden and there was a risk that patients could abscond. All access to the garden for patients was supervised by staff.

Staff had access to alarms through their identification cards, and each room had an alarm on the wall including patient bedrooms.

Maintenance, cleanliness and infection control

The premises were visibly clean. Some bedrooms had curtains hanging off their rails.

Staff followed infection control policy, including handwashing. Staff completed an infection control audit every quarter with any actions identified and a plan developed for them. The most recent one was completed in January 2022. The action required was to maintain the cleanliness of the toaster and microwave as they were in constant use. This action was ongoing at the time of inspection. The service completed a hand hyenine audit.

Staff made sure cleaning records were up-to-date and the premises were clean. We observed domestic staff cleaning rooms and engaging well with the patients.

Clinic room and equipment

The clinic room was small and cluttered with records to be archived. The room could not accommodate an examination couch.

We found an out of date first aid kit in the clinic room. When we pointed this out to the registered manager, they immediately replaced it with a new kit. All yellow topped blood bottles in the phlebotomy equipment pack had expired in December 2021. The grey and purple topped blood bottles were in date. The registered manager told us that the laboratory checked all sample bottles sent down for processing were in date, any with expired dates would be discarded and not tested, and the unit would be informed and asked to provide another sample. They were not aware that any samples sent from the service had been discarded.

Good records were kept of daily room and fridge temperatures, and blood glucose machine calibration. There was a good supply of urine drug screen tests. Staff made regular checks of the emergency equipment.

Safe staffing

Although the service had sufficient staff during the day. At night the service regularly did not fulfil the provider's specified safe staffing skill mix. Insufficient numbers of suitably qualified staff were deployed. Most vacant shifts were covered by agency and bank staff who were regular and received appropriate training.

The provider had set safe staffing levels based on the number of patients admitted to the service. With 15 patients admitted to the unit at the time of the inspection the staffing on the day shift was set as three registered nurses and two support staff, and at night there were two registered nurses and two support staff.

The service had enough nursing and support staff to meet staffing requirements and keep patients safe during the day. However, at night the service regularly did not meet the provider's safe staffing level requiring two registered nurses. The failure to ensure that there was sufficient suitably qualified staff deployed at night meant that there was an increased risk of harm to patients.

The registered manager told us that the provider had introduced a new staffing matrix earlier in the year, following the death of a patient as the result of a choking incident in June 2021 and in acknowledgement that the unit was a standalone service. The registered manager was not able to tell us exactly when this change in staffing came into effect but said it was in 2022, prior to our inspection. The change required there to be two registered nurses and two support workers on every night shift, an increase of one registered nurse.

The registered manager told us it was very difficult to obtain two registered nurses for the night shift. We reviewed the staffing records for the night shifts from the two weeks prior to the inspection and found that there were two registered nurses on the night shift on one night out of 14, rather than every night. On the night shifts when two registered nurses were not available, the second registered nurse was replaced with a support worker.

Additionally, the majority of staff, about 70%, used at night were agency or bank staff. The manager told us bank staff were mostly regular staff, who had received an induction and knew the patients.

At the time of inspection, the service had vacancies for two registered nurses and one support worker. The service was actively recruiting staff, but this had proved difficult especially for registered nurses. The provider was trying a new initiative to recruit internationally for nursing staff, which had had some success.

Staff had a comprehensive induction and the registered manager made sure all bank and agency staff had a full induction and understood the service before starting their shift. The induction for bank and agency staff included the layout, handover, unit routine, key and alarm protocols, how to contact emergency services, provider polices and incident reporting.

The registered manager could adjust staffing levels according to the needs of the patients and obtain additional bank or agency staff if available, such as if a patient needed increased observations. The manager told us it was difficult to recruit additional bank or agency qualified nursing staff. The service had recently added a welcome bonus to seek to attract more applicants to the vacant posts.

Medical staff

The service had enough daytime medical staff and access to on call night-time medical cover to go to the unit in an emergency. Managers made sure all locum staff had a full induction and understood the service before starting their shift. The consultant psychiatrist was new to the service having started working at the service in February 2022. They were still completing their approved clinician training and therefore an approved clinician from a different service was asked to complete tasks and responsibilities related to the Mental Health Act.

Mandatory training

Staff had completed and were mostly up to date with their mandatory training. The overall rate of completion for staff was 95%. Of this, the rate of completion for clinical staff was 90% and for non-clinical staff was 66%, which was two out of three staff. For basic life support training 100% of the clinical team was up to date. Two of the non-clinical staff were still to complete their basic life support training and this had been booked for May 2022.

The mandatory training programme for clinical staff was comprehensive and included ligature risk training, dysphagia, Mental Capacity Act and deprivation of liberty awareness. The registered manager monitored mandatory training and alerted staff when they needed to update their training.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Assessing and managing risk to patients and staff

Staff did not always safely asses and manage risks to patients well. Patient observations were undertaken in a predictable way for patients. Staff did not always record patients' physical health monitoring in a way that was clear when escalation was required or what actions, if any, were taken in response to elevated warning signs. However, when intramuscular rapid tranquilisation had been used, staff completed the patient's physical health observations monitoring as required.

Assessment and management of patient risk

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. At the time of the inspection all patients on the ward were rated green, indicating low risk. When patients were admitted they had a risk assessment within 72 hours of admission. The criteria for admission were that the patient had a primary diagnosis of mental illness with complex comorbidities and a history of treatment resistance. The service only admitted patients that presented with low risk in certain areas such as self-harm, ligature risks and risks to adults and children.

Staff were using a national early warning signs (NEWS) form to record checks of patients' vital signs on a daily basis. The form is used to record the physical health of a patient. Staff collect a range of indicators to produce a score. This shows when a patient's health may be deteriorating. Depending on the score, staff should escalate to the nurse in charge, a doctor, or emergency services. The form had been printed in a way that made it difficult to read and the colour coding did not differentiate between red, amber and green scores. The escalation protocol was missing from the NEWS tool. This made it difficult for staff to interpret the scores staff inputted into the form. Three staff we spoke with could not explain the NEWS escalation protocol. On the second day of the inspection, when we pointed out the condition of the form to the registered manager, they secured appropriate forms with clear colour coding with the escalation process attached. However, staff had been using an unclear and incomplete tool (lacking the escalation protocol) for several weeks prior to the inspection and this put patients at risk of staff not recognising or escalating elevated scores appropriately.

We reviewed the NEWS forms completed for three patients on the ward. NEWS clinical observations were completed at least daily for all patients.

Staff recorded patients' vital signs on the NEWS form and calculated a total score. For one patient we noted they had elevated scores of two, on two different days. There was no record that staff had taken any action in response to these elevated scores in any of their care records, on the NEWS chart or the daily progress notes. Similarly, for a second patient we noted elevated scores of two occasions, recorded on two different days. There was no record that staff had taken any action in response to these elevated scores in any of their care records on either the NEWS chart or the daily progress notes. A third patient scored two on the NEWS and their oxygen saturation was reported to be 92%. There was no information recorded in the patient's notes to show whether staff had taken any action in response to this clinical observation. Staff did not always document whether any action had been taken in response to patients' elevated NEWS scores. There was a risk that staff were not responding appropriately to early warning signs and mitigating the risks to patients of avoidable harm.

Some patients' vital signs were recorded both on their NEWS form and in their electronic records. However, elevated NEWS scores and any subsequent action taken, or explanation why no action was taken or needed to be taken, were not always recorded in the electronic notes.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff were not able to observe patients in all areas as the rooms were over three floors. To mitigate the risk staff recorded observations of patients once during every hour of the day and at night. Records showed that these observations were recorded at set hourly intervals, on the hour.

When patients were required to be observed intermittently by staff, the provider's policy stated that staff were to observe patients four times per hour, with a maximum of 15 minutes between checks. These observations were to be undertaken at unpredictable times so that patients were not aware when the observation would take place. However, when we reviewed the records of two patients who had been on intermittent observations recently, the records stated that staff observed the patients at exactly the same time each hour, at regular 15-minute intervals over a number of days. This meant there was a risk that patients could predict what time staff would be observing them and could plan or carry out risk behaviours between the regular, predictable checks.

Use of restrictive interventions

The levels of restraint at the service were low. Patients whose behaviour resulted in incidents of restraint were referred to an acute service as they presented too high a level of risk for this service. There were two patients in the previous 12 months to the inspection where some form of restraint had been used. For these two patients there were 15 incidents in total and two of these were instances where staff administered intramuscular rapid tranquilisation. Both instances were after other attempts at de-escalation were used including verbal de-escalation. In one instance staff had restrained the patient in a prone position. Where the prone restraint was used this was for 60 seconds in order to administer the intramuscular rapid tranquilisation. Records showed that staff had completed the required physical health observations after the rapid tranquilisation in order to ensure there were no negative side effects affecting the patient.

Of the remaining instances, nine resulted in verbal de-escalation and four involved standing restraint holding the patient's forearm. The records showed patients and staff were debriefed following each incident. There were no instances of seclusion or long-term segregation.

Staff undertook training in reducing restrictive interventions. Staff made every attempt to avoid using restraint by using de-escalation techniques such as speaking to patients, and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff followed the provider's policies and procedures when they needed to search the patients' property or their bedrooms to keep them safe from harm. Staff did not conduct searches on the patients' bodies.

However, we found that restrictive practices were not always reviewed and reduced in a timely way. The bathroom on the first floor had a notice to say that the room always needed to be kept locked. Staff told us that this was because there was a bathtub and a patient liked to take a bath and fall asleep in the bath. The manager told us that patient no longer presented with this risk, but the sign had not been removed and the bathroom remained locked for all the patients.

Safeguarding

Staff understood how to protect patients from abuse and knew who the safeguarding leads were. Staff had training on how to recognise and report abuse. However, not all staff knew how to escalate a safeguarding incident if the registered manager was not present.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. Staff could give examples of how to protect patients from harassment and discrimination.

Staff knew the safeguarding lead for the service was the social worker at the service and the overall safeguarding lead was the clinical manager at another of the provider's services. However, some staff told us that if there was a safeguarding incident when the leads were not available, they would wait until the next day or after the weekend to escalate this to them. They did not know how to escalate a safeguarding concern to the local authority safeguarding team. There was a risk that the patient may come to further harm if there was a delay in making a referral. The registered manager told us there had been two safeguarding incidents in the past year.

Staff access to essential information

Staff did not have easy access to clinical information as records were fragmented across several different systems. We found there was duplication of information in some areas and gaps in others.

Patient care and treatment records were fragmented. Records were kept electronically and on paper. For example, individual prescription charts and NEWS charts were kept in the ward clinic. Records of explanation of S132 rights were kept in an individual paper file or were held electronically by the provider's Mental Health Act office. Patient progress notes and nursing care plans were kept in the electronic patient record. Copies of ward round notes, detailed risk assessments, occupational therapy care plans and summaries, and records of psychology input were held in a separate drive. Outcomes of ward round discussions were not recorded in the patient electronic record which meant there was a risk care plans were not up to date. Each patient had several different care plans prepared by staff from different disciplines in the patient electronic notes and the separate drive, that addressed similar patient needs but were not integrated. By keeping notes about the same patient in several different places there was a risk that patients would not receive holistic care, areas of therapeutic work would be duplicated or gaps in care would occur. To access accurate and up to date information about a patient staff needed to look in several different places. Although the provider had a record keeping protocol in place this was not completely effective in reducing the risks of duplication or gaps in records.

Medicines management

The service had systems and processes to prescribe, administer, record and store medicines, but these were not always safe. Staff did not always record side effects from medicines, and when they did staff did not always record any action taken in response.

We checked a sample of the contents of the medicine storage cupboard located in the clinic room. We found a medication strip with seven tablets of clozapine that had been cut in such a way that the expiry date could not be seen. This raised the risk that patients could be receiving expired medication.

We checked a box of clozapine that was currently in use and while checking it a portion of a tablet fell out. Staff told us told this was because the service only had 100mg tablets of clozapine from the pharmacy and the patient was taking a dose of clozapine that required one of these tablets to be cut into quarters. By cutting the tablet into quarters there was a risk that the patient would not receive an accurate dose. After we pointed this out to the registered manager, they contacted the supplying pharmacy and the service obtained a more appropriate dosage.

Staff did not always monitor or record patients' side-effects from medicines or record actions taken in response to patients' feedback about their side-effects, although the provider told us that patient experiences and side-effects were routinely discussed at weekly multidisciplinary meetings.

For example, one patient reported on the Glasgow anti-psychotic side-effects scale (GASS) form that they experienced daily side effects. This was not recorded in the electronic patient record. The patient's physical health care plan stated that a side-effect monitoring form should be completed 'regularly' but did not state how often it should be completed or what action should be taken in response.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

We reviewed the records of two patients who were being treated with Clozapine. Clozapine affects bowel function in most patients and can produce effects ranging from constipation, which is a common occurrence, to serious problems, including complete blockage of the bowel. The care records of the two patients taking Clozapine did not highlight the risk of constipation and the need to regularly assess patients' bowel function. One patient had a care plan stating they were taking clozapine and that side-effects should be monitored regularly but did not detail the particular side-effects. The second patient had a physical health care plan that stated they were being treated with antipsychotic medication and lithium but did not explicitly mention they were taking Clozapine or highlight the need to check for constipation. There was no record that the risk of harm to the patients from constipation was being regularly assessed, monitored or mitigated.

There were no stool charts for patients in place at the time of inspection. There is a risk of death to patients on Clozapine with bowel obstruction and therefore important to identify constipation as early as possible. We were told that the consultant psychiatrist wanted to implement stool charts for the patients as soon as possible.

Two patients were self-administering medication, they had locked safes in their bedrooms to store their medicines. The staff did spot checks on these to make sure they were being stored and administered correctly.

Controlled drugs and drugs liable to misuse were checked by two nurses for administration. Where there was only one registered nurse on shift, such as at night, a support worker witnessed this. The pharmacy had trained all of the permanent and regular agency support workers to do this. A qualified pharmacist came once a week to check the medicines and prescriptions.

Track record on safety

The service generally had a good track record on safety. However, there was an incident in July 2021 where a patient died after choking on food in the evening.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. The service had no never events in the year prior to inspection. There were three serious incidents in the past 12 months. A patient died after choking, a patient broke their ankle in their room, and there was an incident where a patient stopped washing themselves. All three incidents were reported to the local safeguarding team and notified to CQC as required.

Managers investigated, debriefed and supported staff and patients after serious incidents. Carers were debriefed on incidents as well. We reviewed an aide memoire for post-incident staff debriefs, which included describing the incident, discussing immediate actions, any lessons learnt and identifying any good practice. The incident debrief was documented and staff could access this. There was also a lesson learnt notice on the notice board.

There was evidence that changes had been made as a result of feedback. An incident occurred in July 2021 where a patient died after choking. The lessons learnt from this were discussed in the monthly operational meeting that both permanent and bank staff could attend. All staff received updated training on what do when a patient is choking, as well as updated basic and intermediate life support training.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Requires Improvement

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of patients on or soon after admission. They developed care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. However, there were many different care plan types to cover all aspects of a patient's care. This resulted in duplication of some information across care plans or gaps in patients' care planning.

Staff completed a comprehensive mental health assessment of each patient within 72 hours of admission. Staff assessed patients' physical health soon after admission and regularly reviewed during their time in the unit.

Staff developed a range of care plans for each patient to cover a broad range mental and physical health needs. We reviewed the care plans for five patients. Care plans were individualised, and the patient's voice was evident. However, care plans in the patient electronic record did not contain the level of detail and were not as specific as those prepared by the occupational therapist, who prepared these with patients.

Ward rounds took place every two weeks for patients. Notes of these multidisciplinary meetings were detailed and set out actions and future plans in relation to the patient. However, these plans and actions were not always reflected in the patients' care plans in the electronic patient record.

Staff regularly reviewed and updated care plans when patients' needs changed. However, there were many different care plans to cover all aspects of the patients care. The care plans often lacked detail, and the range of care plans meant some aspects were duplicated across more than one care plan type. The planning of patients' care was not brought together in an integrated way.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audits, although the results of these did not always reflect what we found during the inspection.

Staff provided a range of care and treatment suitable for the patients in the service. The occupational therapist carried out very detailed assessments of patients in relation to their activities of daily living and provided a detailed description of their abilities. The occupational therapist worked with patients to set individual recovery and rehabilitation goals. For one patient the goals included learning to eat healthily and developing independence with self-care. We reviewed records of a community skills assessment carried by staff who observed a patient when they attended a local gym. There were also records of basic cooking skills assessments carried out in the service. Occupational therapy goals were clear, specific and personalised. Two patients were self-administering medicines.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The occupational therapist told us that they had a relationship with the Shaw Trust, a charity that helps service users find employment, where a representative would come and support the patients with writing their resumes and finding employment. One service user wanted to volunteer so the service used their community relationships with the local charity shops to secure volunteer opportunities for them.

Records showed that patients took part in activities in the community including attending a local gym and playing badminton.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff supported patients to pick healthier food through nutrition education groups. Staff arranged dinner for the patients. They worked with patients to put a menu together that met nutritional needs and likes/dislikes of the patients. The fridge and freezers looked clean and well stocked with plenty of fresh fruit. The kitchen was used by the occupational therapist for cooking activities. The occupational therapists conducted catering assessments with patients and supported patients to cook alongside others in group cooking sessions. They aimed to support the patients to self-cater in preparation for move on to the community.

Cygnet Healthcare, the provider, had a no smoking policy in line with National Institute for Health and Care Excellence (NICE) and NHS England, and patients did not smoke on the premises. However, staff facilitated patients' smoking by storing their cigarettes and lighters and dispensed these to the patients three times a day during escorted smoking breaks outside the premises. We were told the service encouraged smoking cessation through initiatives such as nicotine replacement therapy, although staff reported that none of the patients were interested in smoking cessation. One patient used nicotine lozenges to replace smoking, but there were no other patients using nicotine replacement therapy.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Occupational therapists measured outcomes for patients using the model of human occupation screening tool (MoHOST). The assistant psychologist used The Global Assessment Progress (GAP) scoring to measure outcomes. This included looking at whether patients self-harmed, and their physical and emotional regulation.

Staff took part in audits such as monthly care plan and risk assessment audits. The most recent of this audit took place in March 2022 and the outcome was 100%. Although in terms of care plans this did not reflect what we found during the inspection. Results from audits were used to ensure learning and improvements. During a recent hand hygiene audit staff were randomly selected to describe correct handwashing and not all of them knew. Staff then reviewed the stages of handwashing to identify the gaps in knowledge.

Skilled staff to deliver care

The ward team included the full range of specialists required to meet the needs of patients on the unit. 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.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service had a full range of specialists to meet the needs of the patients on the ward. There was a consultant psychiatrist and unit doctor, nurses and support workers, an occupational therapist and occupational therapist assistant and part time social worker. The clinical psychologist for the service had left two weeks prior to inspection, but the registered manager told us a new clinical psychologist would be starting in the next month.

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. The induction programme was three months long and included orientation, information and communication technology, care planning, physical health assessment, risk assessments, care planning, reducing restrictive practice and incident management.

Staff completed specialist training for their roles in addition to mandatory training. This included a course on understanding and supporting patients with autism.

The manager supported the nursing staff through regular, constructive appraisals of their work. Appraisals were up to date for all of the nursing staff.

Medical staff and other clinical members of the multi-disciplinary team received their supervision from their managers at another of the provider's services. The provider's supervision policy required that staff had managerial supervision once every three months, nursing staff had clinical supervision every month, and other clinicians' supervision took place as often as needed in agreement between the manager and staff. Staff told us and records confirmed that they received supervision in line with this policy and they felt the frequency was sufficient. Topics discussed included their well-being, clinical matters and training.

Multi-disciplinary and interagency teamwork

Staff in the multi-disciplinary team worked together to benefit patients. They provided a rehabilitation programme for the patients.

Staff held multidisciplinary team (MDT) meetings every two weeks to discuss patients and improve their care. Staff kept detailed notes of these multidisciplinary meetings that set out actions and future plans for the patient, but these notes were not always reflected in patients' electronic care plans.

The occupational therapist and psychologist worked together to formulate a comprehensive rehabilitation programme with a variety of group learning including life skills and women's health, and recreational activities such as games.

Staff shared information about patients and any changes in their care, including during handover meetings.

The team at Cygnet Lodge Kenton had effective working relationships with other teams in the organisation such as another of the provider's service in the area. The safeguarding lead for the service was based there, along with the supervisor of the occupational therapist.

The MDT had effective working relationships with external teams and organisations such as clinical commissioning groups when a patient needed to be referred to another more appropriate service or discharged into the community.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Staff generally understood their roles and responsibilities under the Mental Health Act 1983 (MHA) and the Mental Health Act Code of Practice. However, patients' rights were either not explained or not recorded as being explained in line with the providers policy. Staff did not seek a second opinion on a patient's treatment when this was legally required in a timely way.

Staff received and kept up to date with training on the MHA and the Mental Health Act Code of Practice. The completion rate for staff for Mental Health Act awareness training was 100%.

Patients had access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the MHA in a way that they could understand. However, this was not repeated in line with the provider's policy. Staff recorded the explanation of patient's rights on an individual form each time they completed it. Staff were required to give an explanation of patients' S132 rights and ensure patients in rehabilitation settings understood their rights routinely at least every three months or when there was a change in status, or the patient asked.

We checked the records of three patients, detained under Section 3 of the MHA, in relation to the provision and understanding of their legal rights under S132 of the MHA.

One patient was newly admitted, and their rights were explained to them on admission. The other two patients last had their rights explained to them in January 2022. However, one patient had their rights explained to them three times between April 2020 and December 2021 rather than the expected seven times. Similarly, for the second patient staff explained their rights to them three times between January 2020 and December 2021, rather than the expected eight times.

These patients were not routinely made aware of their rights under the MHA and consequently there was a risk that they were not always fully informed.

Staff ensured patients could take section 17 leave if there were enough staff to facilitate this. The manager told us that leave for medical appointments was prioritised, and if there was less staff the patients would be escorted as a group or have shorter time on leave. The manager confirmed it did not happen often that leave was cancelled due to short staffing, however records were not kept of how often this happened. At the time of inspection there were five patients on escorted leave. Staff told us that several patients had unescorted leave but needed a lot of encouragement to take it.

The consultant psychiatrist at the service was new, having started in February 2022. They told us that the previous consultant had requested an opinion from a second opinion appointed doctor (SOAD) for an individual patient as required by the MHA. The role of the SOAD is to decide whether the treatment recommended is appropriate when a patient detained under the MHA refuses treatment or is deemed incapable of consenting to treatment. The consultant told us a SOAD was requested for one patient as they did not consent to treatment prior to December 2021. Although the service told us the request for a SOAD had been made in December 2021, and showed us a completed electronic form prior to submission, the request had not been received by the SOAD office. There was no evidence that the service had followed up the request they said they had made, to enquire about the delay. In the meantime, they had continued to treat the patient under S.62 of the MHA. Section 62 of the MHA allows for urgent treatment needing consent to

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

treatment for a patient where a SOAD is required to assess the patient or the patient no longer agrees to treatment. Section 62 of the MHA should only be used for urgent treatment and a SOAD should be requested beforehand. These should be used as long as immediately necessary and should be kept under constant review. The provider told us that patients' medicines were discussed weekly in multidisciplinary team reviews.

SOAD service records showed that a request was made for a SOAD for another patient in November 2021, but records showed the request was two months overdue and Section 62 of the MHA had been in use during the interim period. Following the inspection, the consultant psychiatrist made a request for a SOAD for the patient and this was confirmed with the SOAD service.

SOAD service records also showed that three SOAD requests were made in 2022, one in March 2022 and two in April 2022. One of the April 2022 requests was also a late request for a patient where treatment commenced in August 2021.

Staff stored copies of patients' detention papers and staff could access them on request to the provider's MHA office. There were no informal patients at the time of our inspection.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood and recorded capacity for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act. The completion rate for staff for Mental Capacity Act and Deprivation of Liberty Safeguards training was 100%.

Staff assessed and recorded capacity to consent when a patient needed to make an important decision.

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

Good

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

Kindness, privacy, dignity, respect, compassion and support

Patients and carers told us staff treated patients with compassion and kindness. Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We spoke with seven patients and two carers and we observed a planning meeting with one of the patients chairing. Patients were encouraged to attend and participate in daily planning meetings and weekly community meetings.

We observed and patients told us that staff were kind, respectful, and responsive when caring for patients. Patients told us they liked the activities and there were plenty of them. They enjoyed using the garden. They found the staff polite and friendly.

Patients told us they felt safe on the ward and there was always staff around, although sometimes staff would be too busy to help them.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Patients found the therapies they attended at the service helpful. They said staff supported them to understand and manage their own care treatment or condition and make healthier lifestyle choices.

Patients told us staff had supported them with their religious and other needs, by escorting them to attend meetings and classes.

However, patients told us activities had been frequently cancelled, especially over the pandemic period. Whilst groups had to be cancelled due to social distancing regulations, the patients were provided with activity packs and 1-1 sessions.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients were given a welcome booklet upon arrival which contained information about the service such as how to access independent advocacy, the Mental Health Act, the activity program and policies relevant to the patient. There was a sign immediately after entering the building that informed patients and visitors that CCTV was in use in the building.

Staff made sure patients understood their care and treatment. There was some evidence that staff involved patients in their care planning, such as for their occupational therapy care plans.

Staff involved patients in decisions about the service. We observed a daily planning meeting that was led by the occupational therapist assistant and chaired by one of the patients. The staff worked well with the patients, and everyone had a chance to contribute. Patients told us they also attended a weekly community meeting where they discussed how they were feeling and any improvements they would like to make to the service. Patients could give feedback on the service and their treatment through monthly questionnaires. The occupational therapist and psychologist would use these to make improvements to the service. Examples of improvements made included a patient getting a television for their room, and another patient requested particular games which the service then provided. Patients told us they could make complaints to the manager. Staff supported patients to make decisions on their care.

Staff made sure patients could access independent advocacy services. There was information about the advocate on the noticeboards and in the welcome pack each patient received when they were admitted to the service.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. They were able to attend the weekly ward round and a monthly carers forum. The forum was led by the assistant psychologist and occupational therapist. After the forum the carers complete a questionnaire giving feedback about the service and making requests for changes. Staff and carers told us that changes were made as a result of this feedback. One example was a carer wanted more information on medicines used in the service, so at the next forum the medical team attended and gave a presentation on the medicines and treatments used.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Carers requested to attend ward rounds, and this was facilitated. Carers told us they were able to give feedback about the ward round at the carer's forum.

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

Good

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

Access and discharge

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

Bed management

Bed occupancy was 100% at the time of inspection. The service ensured that patients did not stay longer than they needed to. The service accepted patients from the greater London area and nationally. At the time of inspection there were two patients from outside London, and one patient that had been in the service longer than the average 18 months. The patient with the longest length of stay had been there since mid-2017. This patient wanted to stay in the local community, but they were not from the area and the clinical commissioning group were having difficulty finding a placement.

Managers and staff did not discharge patients before they were ready. When patients went on leave there was always a bed available when they returned. If a patient was assessed as being too risky for the service, they were referred back to the referrer. If there was not a bed available, the patient could be transferred to another of the provider's services, although the manager told us this rarely happened.

Discharge and transfers of care

Staff planned patients' discharges and worked with care managers and coordinators to make sure this went well.

Managers and staff planned discharge from admission. During the first eight weeks of admission target dates were set with care co-ordinators, clinical commissioning groups, carers and the multi-disciplinary team. Staff planned ongoing care in the community and involved GPs. Staff would do follow up calls for seven days after discharge to ensure the patient was settling in. Managers monitored the number of patients whose discharge was delayed. There was one patient with a delayed discharge at the time of the inspection. This was due to the patient's immigration status which made finding a suitable placement difficult when they were well.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could access hot drinks and snacks with staff supervision.

Each patient had their own bedroom, which they could personalise. Each bedroom had a toilet and sink, and there was a communal bathroom on each floor. Patients had a secure place to store personal possessions, and a safe to keep valuables secure.

Staff used a range of rooms and equipment to support treatment and care. There was a separate outbuilding in the garden that was used as an activity room.

The service had quiet areas and a room where patients could meet with visitors in private. Patients could make phone calls in private either in these areas or in their bedrooms using their mobile, or there was a ward phone patient could use.

The service had an outside garden area, but this was kept locked and patient access was supervised. We were told this was because the garden had a low wall, and supervision was necessary to prevent patients absconding.

Patients had the facilities to make their own hot drinks and snacks, but no patients were self-catering. The service offered a variety of good quality, nutritional food that catered to their preferences. Staff supported patients with activities outside the service, such as work, and family relationships.

The service had good relationships with the outside community to facilitate access to opportunities for work for patients. The occupation therapist organised groups for the patients to set up email addresses and assist with writing resumes. One patient had a job at a local charity shop, and the patients were able to use their leave to access the local cafés and parks. The occupational therapist organised outdoor sports for the patients and picnics during the summer.

Staff helped patients to stay in contact with families and carers. Families and carers could visit the patients each day including weekends.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people. The three bedrooms on the ground floor had disabled access and there was a toilet with disabled access on this floor. The service had a lift to support patients with poor mobility to reach all floors.

The manager and patients told us that staff provided cultural and spiritual support by escorting them to meetings and gatherings.

Staff provided patients with a patient guide when they arrived which contained information such as on treatment, local service, their rights and how to complain. Notice boards were also placed appropriately and had useful information such as about local services and activities. However, some notices had very small writing and were difficult to read

The manager made sure staff and patients could get help from interpreters when needed.

There was nothing on display in the service to show that the service was inclusive or welcomed people with a protected characteristic.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Listening to and learning from concerns and complaints

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

Patients, relatives and carers told us they knew how to complain or raise concerns. The service displayed information about how to raise a concern in patient areas.

Managers investigated complaints and identified themes. There had been two complaints in the past 12 months. They were both from a family member of a patient regarding their access to the patient. The patient did not want their family member to access their personal information and the service respected and followed the patient's wishes. Final letters for these were sent in November and December 2021.

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

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

While the manager had the skills and experience for the role, they did not always have a good understanding of how the service was performing. The manager relied on staff and governance systems to report and manage issues, and these did not always work effectively. However, they were visible and present in the service and the staff told us they were always contactable. The staff told us the manager was reliable.

The registered manager had been in post since 2019 and was aware of the key risks and challenges to the service, but not always of the systemic issues. The manager relied on staff and the governance systems to alert them to issues in the service. However, these were not always effective as the manager was not aware of several service issues. These included intermittent observations of patients being undertaken at fixed intervals and the use of unclear forms to record patients' vital signs.

The manager was local to the service and told us they were always on call if there was an emergency at the service. Staff praised the leadership and felt supported by the manager. Staff said morale was good, and colleagues were respectful and got on well.

Staff told us there were leadership opportunities within the service, and the service was currently recruiting for a team leader. The intranet advised that the provider was offering one-year leadership training.

Vision and strategy

Staff demonstrated the provider's values and how they were applied to the work of their team.

Staff told us about their roles in working with the multidisciplinary team to assist patients in taking part in a full activities programme to facilitate their rehabilitation into the community. The registered manager told us that 70% of patients were discharged into the community. We observed that the staff built and maintained good relationships with the patients. Staff treated patients with respect and care in different settings and situations such as community meetings and general interactions. Patients told us that staff were very supportive of them and have helped them progress and improve within the service.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Culture

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

Staff spoke highly of the registered manager. They felt valued in the team and comfortable voicing their opinion with management. Staff were able to escalate their concerns to the manager and service line leads such as the occupational therapist lead for the service. Staff told us they were encouraged to progress in their roles and take on more senior responsibilities.

Staff told us the team culture was good and enjoyed working in the service. The team helped each other out and shared information well. When a serious incident happened, the service provided psychological support for the staff to support them through this time.

Governance

Our findings from the other key questions demonstrated that while the service had governance systems and processes, these did not always operate effectively. Risks were not always managed well, and concerns were not always identified and acted upon.

The registered manager and clinical team leader attended head of department meetings with leaders from the service in Harrow. There were monthly operational meetings attended by the entire service team. These would begin with a general staff meeting and then there was a nurse meeting straight after. Matters discussed included learning from incidents, staff and patient issues, and compliments and complaints. The occupational therapist attended service line and regional meetings every three to four months to discuss issues and evidence-based practice.

There were a large variety of care plans developed by different clinicians which led to duplication of information as well as gaps in care. The service had forms for recording patients' vital signs, but these were incomplete. For example, the section to record whether or not a score was escalated was not always completed in the records we reviewed. There was a lack of assessment of the side effects of medicines. Staff did not follow the provider's policies on the intermittent observation of patients or explanation of their rights under the Mental Health Act 1983.

The service had audits in place, but these did not always assist the service by highlighting concerns. Pharmacy audits were completed, and the outcomes sent to the quality assurance lead who would then feed this back to the service during operational meetings. However, at inspection we picked up several issues with medicines management such as with the ordering and storing of medicines.

Management of risk, issues and performance

There were systems in place to manage risk and issues to the service, however these were not always effective.

There was a risk register in place for the service. The registered manager identified from the risk register that the biggest risk was that the service was a standalone building in the community. This meant the service was isolated if things went wrong, especially out of hours at night and on weekends. To manage this, there was an out of hours on-call rota for managers and doctors where staff could escalate concerns, current risks on the ward were discussed in ward rounds and at multi-disciplinary team meetings on a weekly basis and the provider had increased the number of registered nurses in the service at night. However, the service was regularly unable to obtain two registered nurses at night. When this happened, the manager covered one registered nurse position with a support worker. A new staffing matrix with an

additional nurse on duty at night was put in place earlier in 2022, and the service was recruiting registered nurses to provide additional support. Staff shortages and retention were identified as risks to the service on the risk register. There was an ongoing preceptorship programme for newly qualified staff to attract newly qualified nurses and the manager was to implement a recruitment exercise across different job seeking platforms.

Staff used a form that was to alert them when a patient's physical health may be deteriorating, but they did not understand the escalation process or consistently record their findings and/or actions in the patient record.

Information management

Staff had access to the information they needed, but patient records were fragmented across several systems which made it difficult for staff to effectively track patients' care.

Patient care and treatment records were recorded in a combination of an electronic and paper records. Some patient records were kept on paper, while patient progress notes and nursing care plans were kept in the electronic patient record with ward round notes held in a separate drive. Discharged patients' folders were stacked up in the clinic room waiting to be archived which took up space in a small clinic room.

The manager had access to information to support them with their management role, however it sometimes took time to locate the right information. This included information on the performance of the service, staffing and patient care.

Incidents and safeguarding concerns were reported and investigated, and learning was shared. The service notified the Care Quality Commission of notifiable incidents.

Engagement

The service engaged with patients and staff to plan appropriate services.

There was a patient led daily planning meeting where patients fed back on their daily mood and received their household activities for the day. The minutes from these meetings were made available to the patients. Patients were encouraged to lead these groups.

The service website provided information on the services offered by the unit. Patients and carers had opportunities to give feedback about the service through questionnaires. The occupational therapist and assistant psychologist led the carers forum where carers could learn more about the service, offer feedback and request topics for discussion.

Learning, continuous improvement and innovation

The service shared learning from serious incidents. Staff collected analysed data about outcomes and performance and engaged actively in local quality improvement activities.

Learning from serious incidents took place during monthly operational team meetings and during staff supervision.

The occupational therapist was involved in a local project to improve how information was captured for outcome measures so this would be a shorter more efficient process. Currently the assessment covered patients' routines, physical abilities and environment over 300 questions completed once a month.

The service received the Accreditation for Inpatient Mental Health Services (AIMS). This was awarded on the 25 April 2022, after we inspected the service.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not understand when to escalate physical health concerns and follow up and clearly document actions taken in response to elevated early warning signs. Staff were did not monitor and record side effects from medication used by patients, such as the risk of constipation from Clozapine. Staff did not undertake intermittent observations of patients in line with the provider's observation and engagement policy and did not record these observations accurately. Medicines were not managed and stored appropriately so that expiry dates were clearly visible, and tablets were cut up into small pieces so that the integrity was not maintained.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not enough registered nurses deployed on night shifts in line with the provider's staffing matrix.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not promptly request a second opinion appointed doctor where one was required

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care record system was not cohesive so there was potential for duplication and/or gaps in care and not meeting patients' holistic needs. Staff did not provide clear information to detained patients on a regular basis, in line with the provider's policy, to meet each patient's need to understand their rights under the Mental Health Act 1983.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was not an effective system in place to assess, monitor and improve the quality and safety of the service.