

Cygnets Hospital Harrow






Quality Report

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

Ratings

Overall rating for this location	Good 
Are services safe?	Good 
Are services effective?	Requires improvement 
Are services caring?	Good 
Are services responsive?	Good 
Are services well-led?	Good 

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Hospital Harrow as **good** because:

- Byron ward and Springs wing were clean and well furnished.
- The provider was refurbishing the wards to address ligature risks.
- Patients could access regular one-to-one time with their named nurse and staff rarely cancelled activities and leave.
- Patients said they felt safe on the wards.
- The provider used regular bank workers to cover vacancies and was actively recruiting to fill posts.
- Staff completed patients' risk assessments on admission and reviewed them regularly.
- Most staff were up to date with mandatory training and there were systems in place to monitor this.
- Staff completed patients' assessments on admission and most care records were complete, up to date and personalised to the individual patient's needs.
- Patients had access to a range of psychological therapies recommended by the National Institute for Health and Care Excellence (NICE) guidelines.
- The wards had good multidisciplinary input and respected all staff's clinical backgrounds within teams.
- External stakeholders spoke positively about the relationship they had with the hospital, which provided regular updates on patients.
- Staff understood how to use the Mental Health Act (MHA) and completed MHA paperwork accurately.

- We observed kind and caring interactions between staff and patients on all three wards. Patients' family and carers were involved with their care where appropriate.
- The provider had regular integrated governance meetings and fed this information back to staff teams.
- Staff were positive about their teams, managers and felt respected.

However,

- There were some environmental concerns on Springs unit, including the nature of the environment, layout of the ward, lack of visual signs and the way it served the needs of patients with autism.
- Staff on Springs wing and Springs unit had not completed specialist training in autism. This meant that staff were not adequately trained to understand and manage patients' needs.
- Staff did not always address patients' physical health needs in a timely manner.
- Information stored in patients' paper files was not always easily accessible.
- Staff on Byron ward had not had regular supervision in the last three months.
- Patients admitted to the wards informally did not have clear information about their rights to leave the ward.
- Staff's knowledge on the use and application of the MCA varied across the wards.

Summary of findings

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Good 

Location name here

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient/secure wards; Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Cygnet Hospital Harrow

Cygnet Hospital Harrow is provided by Cygnet Health Care and registered with CQC on 15 November 2010.

Cygnet Hospital Harrow is a 44-bed service over three wards:

Byron ward – 18 beds, mixed acute psychiatric service provides assessment, diagnosis and treatment for a wide range of psychological and emotional problems, including addictions.

Springs unit – 16 beds, low-secure ward for males with autism spectrum disorder, Asperger's syndrome or high functioning autism.

Springs wing – 10 beds, open rehabilitation ward for males with an autism spectrum condition.

We have inspected Cygnet Hospital Harrow four times since 2010, and published the most recent report in September 2014. At the last inspection, Cygnet Hospital Harrow was meeting essential standards, now known as fundamental standards.

Cygnet Hospital Harrow is registered for the following regulated activities:

Treatment of disease, disorder or injury

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

Registered Manager – Seamus Quigley

Accountable Officer – Seamus Quigley

Our inspection team

Team leader: Heather Mah

The team that inspected the service included a consultant psychiatrist, a CQC inspection assistant, a CQC inspection manager, three CQC inspectors, an expert by experience, a Mental Health Act reviewer and a pharmacist inspector.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Visited all three wards, looked at the quality of the ward's environment and observed how staff cared for patients.

Summary of this inspection

- Spoke with 18 patients who were using the service and their family/carers and collected feedback from three patients using comment cards.
- Spoke with the hospital manager, clinical manager and quality assurance manager
- Spoke with the ward managers for each of the wards.
- Spoke with 32 other staff members, including assistant psychologists, catering staff, doctors, domestic staff, healthcare support workers, human resources, nurses, occupational therapists, a psychotherapist and a training coordinator.
- Received feedback about the service from three external stakeholders.
- Spoke with an independent advocate.
- Attended and observed one ward round, one community meeting and one multidisciplinary meeting.
- Looked at 21 care and treatment records of patients.
- Reviewed records of restraint and seclusion.
- Looked at records regarding incidents, training, team meetings, complaints, staffing levels and community meetings.
- Carried out a specific check of the medication management on all wards.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients said they felt safe on the wards. Patients said that staff were kind and polite, and treated them with respect. Patients knew how to make a complaint and could raise concerns in the weekly community meetings. Patients spoke positively about the therapy and activities

on the wards and in the community, although they would like more to do in the evenings and at weekends. Patients said they were involved in their care plans, which included their family/carers where appropriate.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as **good** because:

- Byron ward and Springs wing were clean and well furnished.
- The provider was refurbishing the wards to address ligature risks.
- Patients could access regular one-to-one time with their named nurse and staff rarely cancelled activities and leave.
- Patients said they felt safe on the wards.
- The provider used regular bank workers to cover vacancies and was actively recruiting to fill posts.
- Staff completed risk assessments for patients on admission and reviewed them regularly.
- Most staff were up to date with mandatory training.

However,

- There were some environmental concerns on Springs unit.

Good



Are services effective?

We rated effective as **requires improvement** because:

- Staff on Springs wing and Springs unit had not completed specialist training in autism. The provider had not adequately trained staff to understand and manage patients' needs.
- Staff did not always address patients' physical health needs in a timely manner.
- Information stored in patients' paper files was not always easily accessible.
- Staff on Byron ward had not had regular supervision in the last three months.
- Patients who were admitted to the wards informally did not have clear information about their rights to leave the ward.
- Staff's knowledge on the use and application of the MCA varied across the wards.

However,

- Staff completed patient assessments on admission and most care records were complete, up to date and personalised to individual patients' needs.
- Patients had access to a range of psychological therapies recommended by NICE guidelines.
- The wards had good multidisciplinary input and respected all staff's clinical backgrounds within teams.

Requires improvement



Summary of this inspection

- External stakeholders spoke positively about the relationship they had with the hospital, which provided regular updates on patients to them.
- Staff understanding and use of the Mental Health Act (MHA) was good and paperwork was completed accurately.

Are services caring?

We rated caring as **good** because:

- We observed kind and caring interactions between staff and patients on all three wards.
- Patients' family and carers were involved with their care where appropriate.
- Staff discussed patients respectfully during ward rounds.
- The wards had regular community meetings where patients could provide feedback and report any concerns.
- Care records showed staff worked to engage patients in care planning.
- Patients received an information guide and introduction to the ward on admission.
- Patients had access to a range of activities at the hospital and in the community, although some told us they would like more to do during the evenings and weekends.

Good



Are services responsive?

We rated responsive as **good** because:

- The hospital had well-equipped occupational therapy rooms, a laundry room, gym, multi-faith room and large garden.
- Staff and patients said the food was generally good.
- Staff could access interpreters when needed.
- Patients knew how to raise a complaint and staff managed these appropriately.

However,

- Patients' confidentiality was not always maintained on Springs unit, as the ward board was visible from the ward.
- The environment of Springs unit was not autism friendly. It did not have visual signs and the lay out made it difficult to reduce noise.

Good



Are services well-led?

We rated well-led as **good** because:

- The provider had good systems in place to monitor mandatory training.

Good



Summary of this inspection

- The provider had regular integrated governance meetings and fed this information back to staff teams.
- The provider completed regular audits and ensured actions were completed.
- Staff were positive about their teams, managers and felt respected. Staff could report any concerns to their managers.
- The provider was committed to improving the quality of care on an on-going basis.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983 (MHA). We use our findings to help us determine an overall judgement about the Provider.

- Eighty nine percent of Cygnet Harrow staff had completed training in the MHA. Staff said they felt confident in using the MHA and were familiar with its code of practice.
- There was a clear MHA process flowchart in the ward office. Staff said their MHA administrator was helpful. The MHA administrator could provide additional mentoring and support to staff for any queries regarding the MHA.
- Staff said they informed all patients of their rights under the MHA and documented this in patients' files. However, the three files we inspected on Springs wing did not all contain a record of patients being told their rights, although one of these patients confirmed staff told them their rights.
- On Springs wing, staff ensured patients understood the provisions of the MHA that applied to them and their right to appeal to the tribunal when they were placed under the MHA and when their section was renewed. We did not find evidence that this was carried out on other occasions. Patients had regular access to an advocate who visited the wards regularly. The advocate confirmed that staff were supportive of advocacy and regularly referred patients requiring support to the advocacy service.
- Staff filled detention paperwork correctly. All patients had their legal status and dates for renewal recorded. The treatment forms were with patients' medication charts as required.
- On Springs unit, staff made referrals to second-opinion appointed doctors where appropriate. However, one patient on Springs wing was waiting for a medication change to be authorised by a second-opinion appointed doctor. The required paperwork was not completed in a way, which complied with the MHA.
- Assessments of capacity to consent to treatment were not carried out on a regular, systematic basis.
- Information in a leaflet given to informal patients regarding their right to leave the hospital showed that informal patients might not be fully aware of their rights to leave the hospital at will. This leaflet stated that informal patients could only leave the hospital grounds 'with the consent and agreement of the nursing staff/responsible Clinician'. In addition, the board in Byron ward's office indicated a leave status of "Leave Not Recommended" for all informal patients on the ward which possibly compromised their freedom of movement.
- Cygnet Hospital Harrow maintained a database on patients' MHA details including their MHA status, date of section and expiry, consent to treatment and dates of tribunals and hearings. The provider had an integrated governance and integrated audit meetings every other month that included monitoring MHA compliance. All of Cygnet's MHA administrators met at MHA governance meetings twice a year to evaluate current practices and discuss updates to the MHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Although most staff across the wards completed training in the Mental Capacity Act (MCA), their knowledge of the MCA was variable. It was not always clear how they were supporting patients to make relevant decisions. Staff on Springs unit did not always record that they had assessed an individual's capacity to make a decision when it was necessary to do so. Staff on the Springs wing knew of the policy developed by Cygnet relating to the MCA. Reading the MCA policy is part of their mandatory training. It was also available for staff to read on the staff database. The provider reviewed this policy






Detailed findings from this inspection

in September 2015. However, when we looked at the policy, the provider had not updated it to reflect important legal changes effective from April 2014 regarding DOLS.

- The ward doctor usually completed the consent to treatment part of the psychiatric assessment form upon admission. However, staff did not regularly follow up on consent and capacity issues.
- Staff said they had never considered the use of Deprivation of Liberty Safeguards (DOLS) on Byron ward. The staff on Springs wing had not made any applications for DoLS in the past 12 months. There were no patients subject to DoLS at the time of our inspection.
- Springs unit staff assessed the capacity of patients to budget and manage their own money.

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

Good 

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

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Good 

Safe and clean environment

- Byron ward was clean with all rooms en-suite except for the three observation rooms behind the nursing station. The ward had spacious and well-decorated lounge areas and a well-kept garden.
- The wards did not have clear sight lines throughout, but the observations process and the use of CCTV cameras mitigated this. There was no seclusion room on the ward.
- The ward had ligature anchor points on the handles of bedroom doors and in the ensuite bathrooms. However, a works programme was underway to replace these. Two rooms at a time were being worked on with approximately nine weeks of work left to complete on the ward. Staff mitigated these through regular observation of the ward.
- The ward was mixed gender, but adhered to guidelines on same sex accommodation through careful allocation of rooms following risk assessments. The three observation rooms were never mixed gender because they shared a communal bathroom. There was a female-only lounge.
- The observation rooms had transparent walls to enable staff to see the areas around it and were located behind the nursing station so that other patients could not see

into them. Patients with increased levels of risk were transferred to these observation rooms and staff rapidly moved patients into ensuite bedrooms once the level of risk diminished.

- All staff had fobs with alarms. The ward had a radio communications system on the unit and staff completed health and safety assessments on a quarterly basis.
- The clinic room was small and cramped with no sink or couch. However, the medication was neatly ordered and there was a separate controlled drugs cabinet. The checklists and stock lists for all the drugs and ordering/disposal procedures were up to date and clear. The fridge was clean and in good working order with fridge and room temperatures logged on a daily basis. Staff knew what action to take if the temperatures fell out of the acceptable range.
- Stocks of medication were full and staff ordered medication online, which would arrive by courier the same day if ordered by 10am.
- The ward kept a resuscitation grab bag in the nursing station. This included oxygen, defibrillator equipment, airways suction equipment and emergency medication. Staff regularly checked the bag for contents and function.
- There was easy access up the stairways to the Springs wing from Byron ward, enabling patients from both locations to move freely between wards. Some Springs wing patients had their own fobs, which may have affected the security of Byron ward. There had recently been an incident when staff found a patient from the Springs wing in the room of a patient on Byron ward. Following our visit, the hospital manager provided

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

Good 

proposed refurbishment plans that involved relocating Springs wing to a new unit on the hospital site and would allow separate entrances for each ward. The refurbishment work is due to start in the spring of 2016 with an aim to be completed in July 2017.

- The entrance to the ward had hand gel dispensers. However, we observed five members of staff entering the ward without using the gel.
- The garden fence had only been in place for a year. There had been fewer patients going absent without leave as a result but patients were able to climb over the fence quite easily. In the 21 incident reports we reviewed, three involved a patient going absent without leave.

Safe staffing

- The senior nursing team on Byron ward comprised a ward manager, and three charge nurse team leaders. There was one vacancy for a qualified nurse and one vacancy for a healthcare support worker. There was a full-time occupational therapy vacancy at the time of our visit.
- Medical input consisted of two consultant psychiatrists who dealt with a maximum of nine patients each. Both had private admission rights. There was a ward doctor working three days a week, with a locum ward doctor for the remaining two days. A duty doctor rota system operated from 5pm to 9am and at weekends. Duty doctors could generally get to the ward within 20 minutes.
- There was an easily accessible Cygnet bank worker system for qualified and unqualified staff. The ward often needed bank workers because of observation levels. Bank workers were usually well known having worked on the ward before. On rare occasions it was necessary to use agency staff. The ward provided agency staff with a basic induction. The hospital invited the agency to send staff to Cygnet training sessions so they would know Cygnet policies and procedures when the time comes.
- The staff matrix system allowed for a minimum of two qualified nurses and two healthcare support workers at

any one time. Once the number of patients rose to 17 patients this increased to three and five respectively. The ward could use additional staff for one to one observation requirements.

- The ward manager said that recruitment was not a problem but that retention was an issue especially for healthcare support workers. Seven substantive staff, including five healthcare support workers left the ward between 1 September 2014 and 31 August 2015. The ward did not have a strategy in place to address staff retention.
- Staff said that they very rarely cancelled leave because of staffing issues. Patients said they could usually take their leave.
- Sickness levels on Byron ward from 1 September 2014 to 31 August 2015 was 2.3%.
- Staff at Cygnet Harrow were 88% compliant with mandatory training in September 2015. A training coordinator managed training completion using a monthly training report and training matrix.

Assessing and managing risk to patients and staff

- There was no seclusion room on the ward and no reported incidents of seclusion in the past 12 months. The clinical manager said they did not use seclusion on the ward and they assessed patients based on risk, past history and current presentation and did not admit patients assessed as being too acutely unwell and who may require seclusion. Staff managed patients who became acutely unwell by using various approaches including verbal de-escalation, PRN “as needed” medication and/or increasing the patient’s observation level. Staff said they tried to use verbal de-escalation and that there was always a prevention and management of violence and aggression (PMVA) instructor on shift. If a patient required seclusion facilities, staff liaised with their referring trust to transfer the patient psychiatric intensive care unit (PICU) bed within the trust or a private bed. The five patients we spoke with on the ward had not been secluded during their admission.
- Staff said that if necessary they would try to restrain in the patients’ rooms. If staff had to restrain in a common access area, staff said they would try to lead other patients away. Figures provided by the hospital

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

Good 

indicated there were 15 incidents of restraint in the past six months, seven prone, of which five required rapid tranquilisation. Observations would always be increased after restraint and there would be debriefs for staff. After incidents, staff completed restraint and rapid tranquilisation forms. Restraint records showed that doctors completed all necessary observations and that they did not last for long periods.

- The ward had a clear a screening process for new referrals. Staff completed short term assessment of risk and treatability (START) risk assessments on all new patients.
- The ward had restrictions on bringing illegal drugs and alcohol onto the ward. Staff checked patients' property on arrival. Staff did not remove mobile phones unless there was a distinct reason such as patients taking photos or making nuisance calls. Staff treated laptop computers the same way. However, staff did not permit patients to keep their own chargers.
- Staff said they had a good relationship with the Harrow safeguarding team. Safeguarding was part of mandatory training. Staff said they often did not get to know the outcome of safeguarding concerns they had raised with originating trusts because patients returned to the trusts.
- Staff responded to emergencies on other wards when the alarms were set off. If involved in incidents on the other wards those staff were invited to have a debrief about the incident.
- Staff used the board in the nursing office to rate patients on a red, amber and green risk basis.
- The provider had appropriate arrangements in place for obtaining medicines. Staff told us how medicines and supplies were available so patients could have their medicines when they needed them. We checked the medicines for 33 patients and saw no medicines were out of stock.
- The provider stored medication securely. Medicines requiring cool storage where stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use.

- The provider stored and managed controlled drugs appropriately. It was the provider's policy to store and record the use of all benzodiazepines in its register of drugs liable for misuse.
- The provider had appropriate arrangements in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving patients their medicines were recorded.
- The provider had weekly visits by a pharmacist who checked staff gave medicines safely to patients and recorded the administration of medicines correctly. Staff checked Mental Health Act (MHA) compliance, prescription writing and patient details.
- Medicines in the emergency resuscitation packs were fit for use. However, none of the wards had any flumazenil injection available, which is used to reverse the central sedative effects of benzodiazepines. As lorazepam injection was used for rapid tranquilisation a risk assessment is required to determine if this should be available to treat patients if they experienced respiratory depression. Staff on Byron ward and Springs unit told us they would order some from pharmacy that day.

Track record on safety

- The ward manager said that the ward had one serious assault of a nurse by a patient last year. There were no serious incidents recorded for Byron ward in the last 12 months.

Reporting incidents and learning from when things go wrong

- The ward had incident forms, restraint forms and rapid tranquilisation forms readily available for any staff member to complete. We saw the ward manager checked these after completion, signed them off and then monitored by clinical management.
- Cygnet had an internal bulletin on serious incidents from across the wider Cygnet group and also a corporate lessons learned log. The ward manager invited staff to read serious incident investigation reports and sometimes discussed them in the reflective practice group.

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

Good 

- We reviewed 21 incident reports going back to May 2015. The ward had seven restraints (four on the same patient), four prone with one resulting in rapid tranquilisation. The records all matched across the three books: incidents, restraint records, rapid tranquilisation records. No seclusion was recorded. Three incident forms recorded patients jumping over the fence and leaving the hospital.
- All the records contained mental health recovery and problem behaviour care plans. Most of the interventions listed were common to all the care plans. The continuous written records were legible and detailed and made constant reference to the care plans, providing information about progress towards recovery goals. In two of the records, staff had not completed the consent for information sharing form.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?
(for example, treatment is effective)

Good 

Assessment of needs and planning of care

- Patients had a full physical health assessment upon admission, as evidenced by the care records and staff contacted the GP for medication reconciliation. Staff cut short many physical health interventions due to patients being recalled to their home services.
- Sometimes staff had to transfer patients to Northwick Park Hospital A&E. For example, a patient with breathing problems was recently taken there. This showed staff addressed patients' physical health needs appropriately.
- The ward had a nursing handover at 7.15am and 7.15pm and a multidisciplinary meeting at 9am every weekday. The ward also had a reflective practice group on Tuesdays and a community meeting for patients and staff on Wednesdays. All patients had access to the consultant psychiatrists twice a week.
- We reviewed nine care records. All had a psychiatric assessment including a brief statement of capacity. Each record contained a START risk assessment but these often did not contain much information or formulation. All the records contained a medical history and physical health examination completed in considerable detail as well as health of the nation outcome scale scores. Three of the records included patient health questionnaire-9 (PHQ-9) and alcohol problems questionnaires.

- We saw that in one record where there was potential to consider safeguarding procedures, this was not done. Only two of the care records seemed to contain weekly summaries or typed ward round notes which could be sent to the originating trusts.
- The provider kept all of the patients' records in paper files and not electronically. This meant that information was not always easily accessible. Staff said that they would find an electronic care record more helpful than the current hand written system.

Best practice in treatment and care

- A wide range of NICE compliant therapies was available to patients on the ward. Four psychotherapists offered sessions including cognitive behaviour therapy (CBT), resourcing, coping strategies work and EMDR (eye movement desensitisation and reprogramming).
- Staff provided therapy in groups and in one to one sessions.
- The psychotherapist said the discipline was valued and respected by colleagues. They said that MDT discussions about de-escalation and psychological interventions had led to a reduction in the use of PRN medication on the ward.
- The psychotherapist facilitated the reflective practice group on the ward. This was an open forum for anyone in the team to come and explore issues and share information. For example, the meaning of least restrictive practice.
- Staff confirmed that all patients, regardless of which part of the country they had come from, were registered to the local GP.
- The wards completed various audits including patient satisfaction, health and safety, clinical records, medicines management, infection control, physical healthcare and health and safety.

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

Good 

Skilled staff to deliver care

- The ward had medical, nursing and healthcare support worker input on the ward. There was very good psychology input offering a range of different therapies.
- Staff said that the ward really needed an occupational therapist and recruitment was underway for this vacant post. One patient said that since the OT recently left that the ward was quieter during evenings and weekends.
- The ward did not have a social worker and some staff thought it would be useful to have one to help with liaison with community teams as well as taking a lead on safeguarding and mental capacity.
- The ward had a supervision tree and it was clear who supervised whom. Supervision was supposed to be on a monthly basis and the ward manager said there was also a lot of informal supervision. Regular bank workers were also offered supervision. Although all staff had a signed supervision contract records showed that no staff had had three supervision sessions during the past three months, leaving the ward 100% non-compliant with the target.
- Nurses and healthcare support worker's appraisals were supposed to take place on a yearly basis but many of these were overdue for the year.
- A training coordinator created a yearly training plan for clinical and non-clinical staff that included specialist and mandatory training courses.
- Specialty doctors completed annual mandatory training as well as in-house training programmes including the recovery star, START assessment. Each doctor completed annual appraisals with their supervising consultant and regular supervision. Cygnet's group medical director manages the revalidation process centrally.

Multidisciplinary and inter-agency team work

- We observed an MDT review/ward round. Staff discussed five patients in detail. There was an informed discussion with good input from all disciplines.
- There were two consultants on the ward and a ward doctor three times a week that provided constant cover during the week.

- The ward had three psychotherapists and one CBT psychologist who gave input into the ward and Springs wing.
- All staff, including a student nurse and the support workers said that the ward operated in a multidisciplinary way and that all clinical backgrounds were respected. All staff said they felt valued members of an effective team.
- External stakeholders spoke positively about the relationship they had with the hospital, which provided regular updates on patients to them. They told us staff were professional, communicated effectively and included both patients and their family/carers in their treatment pathway.

Adherence to the MHA and the MHA Code of Practice

- Eighty nine percent of staff at Cygnet had completed MHA training. The MHA administrator could provide additional mentoring and support to staff for any queries regarding the MHA.
- Staff said they felt confident in using the MHA and were familiar with the code of practice.
- There was a clear MHA process flow chart in the ward office. Staff said MHA administrator was helpful.
- The board in the ward office indicated a leave status of "Leave Not Recommended" for all informal patients on the ward which may have impacted upon the way in which informal patients' rights were perceived by staff.
- The T2 and T3 forms were not attached to the drug charts and were not kept on the ward, which meant that information relating to consent to treatment was not ready to hand for staff.
- Sometimes there were disagreements between the Harrow approved mental health practitioner (AMHP) team and the local AMHP teams over who should take responsibility for completing patients' mental health assessments under the MHA. This had not led to patients being illegally detained, but it did mean that some patients were assessed near the end of section 2 and section 5.2 time limits.

Good practice in applying the MCA

- Staff said that they felt less confident in the application of the Mental Capacity Act (MCA) than the MHA.

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

Good 

- One of the consultants said that the ward staff needed more training on capacity.
- The ward doctor usually completed the consent to treatment part of the psychiatric assessment form upon admission. However, staff did not regularly follow up on consent and capacity issues.
- Staff said they had never considered the use of deprivation of liberty safeguards (DoLS) on the ward. There were no patients subject to DoLS at the time of our inspection.
- Staff said that they could obtain advice and guidance on the MCA from Cygnet's company solicitors. They also said that the same solicitors provided their MCA training.
- Patients had access to a Mind advocate once a week on Thursdays and staff noted advocacy appointments on the board in the staff office.
- The regular community meetings afforded patients the opportunity to give feedback about the care they were receiving and to report any concerns they had with practical or maintenance issues. Staff made every effort to ensure that these issues were addressed swiftly and the manager responsible for the upkeep of the building attended the community meeting.
- Care plans indicated that staff had made efforts in each case to get patient input into the planning process. Sometimes they were not successful but the continuous written records detailed attempts to engage the patients in care planning.
- Patients said staff told them about their medication and were positive about the activities they accessed. Some patients were unsure about their discharge plans.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good 

Kindness, dignity, respect and support

- We observed several interactions between staff and patients on the ward and in each case the staff member showed courtesy and kindness towards the patient. For example, a nurse skilfully comforted a patient on one to one observation when she became upset at not being allowed to leave the ward.
- We observed a community meeting for patients and staff on Byron ward. During this meeting staff interacted with patients in a kind and respectful manner, giving them encouragement and support in articulating difficult feelings. Staff showed considerable patience and an ability to calm an angry patient and offer reassurance.
- All five patients we spoke with said staff were kind, caring and respectful. One patient's daughter told us they could call the nursing station anytime to speak with them. Another patients; family who lived outside of London had come to visit.

The involvement of people in the care they receive

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good 

Access and discharge

- Byron ward staff tried to respond to all referrals within one hour. Referrals came through at any time and from all over the country.
- Demand for beds on Byron was high but patients could return at any time to the referring trust. This led to some disruption and to staff feeling they were not able to complete the recovery journey with patients.
- At the time of our inspection there were ten patients on the ward. Patients came from trusts around the country including Nottingham, Birmingham, Avon and Wiltshire, Bedfordshire, Cornwall and South London.
- The average length of stay was seven to 10 days.
- Staff expressed some frustration at the frequency with which patients were recalled. This meant that recovery and discharge planning was often cut short by the sudden return of a patient to a bed in their local area.

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

Good 

- Staff had regular communication with the patients' referring home trust and liaised with bed managers, care coordinators and home treatment teams to manage discharge. Relatives, carers and care coordinators were invited to ward round meetings and occasional staff from the patient's home Trust's discharge team also attended. Staff from the patient's home Trust's crisis or home treatment team communicated with the patient prior to discharge. The ward staff faxed discharge notifications to the crisis or home treatment team and patient's GP before the patient was discharged including information about their medication.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward was clean and comfortable with new furnishings in evidence.
- There were well-equipped OT rooms, a laundry room and a multi-faith room just outside the ward.
- The hospital provided meals in the restaurant with table service and a choice of food. The kitchen could provide for any dietary requirements. Staff and patients said the food quality was generally good.
- The ward had a ward pay phone, and patients could also ask to use the phone at the nursing station. There were also phones in the bedrooms.

Meeting the needs of all people who use the service

- The ward had disabled access including wheelchair access.
- Interpreters were readily available, for example a Hungarian interpreter was booked for a mental health tribunal during our inspection.
- Most staff completed training on equality, diversity and disability.
- Staff said they could help patients to access imams, rabbis and other religious ministers.

Listening to and learning from concerns and complaints

- In the past 12 months there had been six complaints relating to Byron ward, two of these were upheld.

- There was a complaints leaflet in the folder that staff gave to all new patients. The ward manager said that he looked at all complaints initially and would try to resolve matters swiftly. For example, when a patient who felt one of the nurses on nights was making too much noise, the manager spoke to the nurse and the patient was satisfied.
- Patients said they knew how to make a complaint and could raise any concerns in the weekly community meetings.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good 

Vision and values

- Staff were aware that the Cygnet group had recently been taken over by a larger company. They said they felt the values of the organisation would stay the same and that they thought these values were about providing a high quality and personalised service to all patients.
- Staff said they identified with the hospital more than the wider Cygnet group. They did not know the names of senior managers in the Cygnet group.

Good governance

- The medical secretaries updated the mandatory training record and the ward manager was given a monthly update.
- The hospital's combined record showed low completion rate for Clozapine Dose Titration, Prescription Writing and Administration Standards and Rapid Tranquilization courses.
- The service had an integrated governance meeting every two months. The agenda for these meetings had changed recently. The regular agenda now included medication management, risks, restraints, physical interventions, security and recent audits.
- Each ward had a recently implemented overarching local action plan (OLAP) that included health and safety, quality network reviews and the service environment. These areas were red, amber and green (RAG) rated,

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

Good 

updated monthly and included recommendations, the accountable person, resources required and action plans. Some actions were also allocated to the local risk register. The hospital manager trained the heads of departments on using the OLAP to ensure information filtered down to team meetings.

- Cygnet's main office completed recruitment including interviewing and employment checks. The hospital manager could set criteria for shortlisting and participated on interview panels. Staff records were up to date including occupational health, references, work permits, proof of identification and professional memberships.
- Cygnet Harrow's hospital manager reported to the operations manager, who reported to the organisations chief operating officer. The hospital manager attended regular meetings with other Cygnet hospital managers from other sites for information sharing.
- The quality assurance manager acted as a link between the local governance and corporate governance and covered eight Cygnet sites across the south west and south east of the country.
- Cygnet had an internal bulletin on serious incidents from across the wider Cygnet group and also a corporate lessons learned log. The ward manager invited staff to read serious incident investigation reports and sometimes discussed them in the reflective practice group.






Leadership, morale and staff engagement

- All the staff we spoke with said that they enjoyed working on the ward and that the team was supportive and cohesive.
- The morale on the ward was high and all staff felt that the team respected them and listened to their views.
- Staff said that they felt they could report any concerns to their managers without fear and that the hospital was committed to improving the quality of care on an on-going basis.
- Some staff favourably compared the intimate and family type atmosphere in the hospital with their experiences in larger institutions.
- Staff spoke highly of their line managers.

Commitment to quality improvement and innovation

- Therapy staff said they hoped to further develop the range of therapies offered to patients to make Byron ward sought after for non-medical interventions.
- Byron ward deferred their AIMS accreditation following peer review in November 2014 due to recommendations made regarding the fabric of the building, particularly around the ligature points. The board approved this improvement programme and was currently in progress.

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Good 

Safe and clean environment

- The Springs unit was over two floors. Staff in the upstairs of the ward, where the bedrooms and lounge were located, could observe patients from the nursing station positioned to allow observation of the two corridors. The stairwell area was kept locked. The service had positioned convex mirrors to allow staff to observe blind spots under the stairs. The service was in the process of installing CCTV. At the time of the inspection, it did not cover all areas of the ward. Staff kept the gym and occupational therapy room downstairs locked. Staff supervised patients when they had access to these areas.
- Staff had completed a ligature audit of the unit in February 2015. The service had been undertaking work to reduce ligatures on the unit. All but one bedroom had been refurbished with new doors and ligature free wet rooms. The service had not refurbished the final room to allow continuity for the patient whose room it was.
- The sensory room had a number of hazards, including plugs and light fittings. This room was only accessed by patients under staff supervision.
- The ward had a fully equipped clinic room. The resuscitation equipment and emergency drugs were kept in a bag in the ward office, which was kept locked.

The bag included two types of ligature cutters. Staff knew where the equipment was kept. Staff checked the equipment regularly and recorded that they had done so.

- The ward had a seclusion room, which was located at the end of the main bedroom corridor. It had been recently renovated. The room allowed for clear observation, two-way communication and had toilet facilities and a clock.
- The service had regular cleaning staff. We saw completed daily cleaning checklists completed by staff for the hospital areas. However, on the day of the inspection there was a strong smell of urine in the sensory room and upstairs corridor.
- Some areas of the ward were cluttered. For example, in the occupational therapy room there was a wheelchair being stored. Staff told us this was for the use of a patient who had been discharged. The gym contained some unusable items of equipment, including an exercise bike without a seat. The garden contained a number of deflated footballs.
- Staff completed training in infection control and understood their role. 96% of staff had completed the mandatory training.
- Cygnet Hospital Harrow was awarded a Food Hygiene Rating of 5 (Very Good) by London Borough of Harrow on 3 March 2015.
- An anti-bacterial gel dispenser was available outside the entrance to the ward.

Forensic inpatient/secure wards

- At the time of our inspection, the service was in the process of installing new doors to ensure it met with guidance following a recent inspection by the London Fire Brigade.
- All staff and visitors carried personal alarms while on the ward.
- The service had completed an audit to ensure that it met guidance for the security required on a low-secure unit. The ward had a secure perimeter including a fence around the garden. Everyone entering and leaving the ward though the door entered through an air lock. One member of staff on all shifts was the designated security member of staff.

Safe staffing

- The ward had seven members of nursing staff on a day shift: three qualified nurses and four healthcare assistants. At night there were four members of nursing staff: two qualified nurses and two healthcare assistants. In addition to this there was a member of staff in charge of security at all times. If one patient required enhanced one-to-one observations, this would be done using the set numbers. Should more than one patient require enhanced one-to-one observations the ward would have access to extra staff.
- Between 1 September 2014 and 31 August 2015 the ward had a vacancy rate of 11.5%. In August 2015 the ward had three registered nurses vacancies. The ward was using bank workers to cover the vacancies. Between 12 May 2014 to 12 August 2015, bank workers covered 352 shifts. The unit used bank workers that were familiar with the ward whenever possible.
- Escorted leave or ward activities were rarely cancelled because there were too few staff. Patients told us they could usually take their leave.
- The ward doctor worked on the ward from Monday to Friday. The consultant visited once a week for the ward round. The ward had an on call rota system for medical cover at nights and weekends.
- Staff had received appropriate mandatory training, which included training in safeguarding, fire awareness, the recovery approach STAR, and equality and diversity. Most staff were up to date in most courses. The service had 87% of staff or more up to date in each course.

Assessing and managing risk to patients and staff

- Staff discussed and updated the risk of patients at daily handover. Staff checked patients' risk prior to accessing leave in the community.
- Staff carried out random patient and room searches. These usually involved asking patients to empty their pockets and allow staff to see what was in their bags. Staff completed random room checks each week. These usually were environmental checks and carried out with the patient.
- The service updated its policy for 'The prevention and management of violence and aggression' in August 2015 to reflect recent changes to guidance.
- Staff completed training in using prevention and management of violence and aggression. Staff received training in promoting safer therapeutic services (PSTS) by Cygnet in-house instructors who are trained under the auspices, professional codes of practice for West London Mental Health Trust. 100% of staff were up to date with PSTS training.
- Staff documented incidents of restraint in the ward restraint book. Restraint records were detailed and included information on the type of restraint and duration.
- The hospital used the seclusion room for patients from the Springs wing that patients accessed through a connecting door located at the back of Springs unit.
- The service completed monthly audits of restraint which staff discussed at their clinical governance meeting.
- Between January and June 2015, staff restrained patients 53 times. Five of these incidents had been in the prone position.
- The provider was aware of recent guidance on reducing the use of prone restraint and had reviewed this in recent audits.
- Staff recorded incidents of seclusion in a seclusion book. Staff had fully completed three out of four records we reviewed. One record did not have the time the seclusion finished recorded. Between February and July 2015, the ward reported 13 incidents of seclusion. There were no incidents of long term segregation reported.

Forensic inpatient/secure wards

- Staff completed safeguarding training and most knew how to raise concerns, although two members of staff we spoke with were not clear in their answers. 87% of staff were up to date with safeguarding adults mandatory training. The service had raised safeguarding referrals appropriately with the local authority and CQC.
- The service kept patients' money locked in the security room. Staff recorded all transactions in a book.
- The provider had appropriate arrangements in place for obtaining medicines. Staff told us how medicines they obtained and supplies were available to enable patients to have their medicines when they needed them. We checked the medicines for 33 patients and saw no medicines were out of stock.
- The provider stored medication securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use.
- The provider stored and managed controlled drugs appropriately. It was the provider's policy to store and record the use of all benzodiazepines in its register of drugs liable for misuse.
- The provider had appropriate arrangements in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving patients their medicines were recorded.
- The provider had weekly visits by a pharmacist who checked staff gave medicines safely to patients and recorded the administration of medicines correctly. Staff checked MHA compliance, prescription writing and patient details.
- Medicines in the emergency resuscitation packs were fit for use. However, none of the wards had any flumazenil injection available which is used to reverse the central sedative effects of benzodiazepines. As lorazepam injection was used for rapid tranquilisation a risk assessment is required to determine if this should be available to treat patients if they experienced respiratory depression. Staff on Byron ward and Springs unit told us they would order some from pharmacy that day.
- Patients who staff recorded as being administered lorazepam injection for rapid tranquillisation had appropriate documentation on their rapid tranquillisation observation records.
- Children were not allowed onto the ward to visit. If a child visited a patient, they would meet in the meeting rooms elsewhere in the hospital.
- Staff undertook gatekeeping assessments of patients prior to admission to see whether they meet the criteria for the unit.
- The ward had some patients with high needs, who were presenting with difficult to manage behaviours. A number of staff raised concerns with us regarding the ability of the unit, as a low-secure unit, to meet the needs of these patients without impacting on other patients on the ward.
- Staff undertook risk assessments using the HCR-20V3 (Historical clinical risk management–20, version 3) and START risk assessment tool. Staff had completed and updated these assessments in all six files we reviewed. Staff had completed risk assessments in all six patient files we reviewed.
- The psychology department took the lead on HCR-20V3 risk of interpersonal violence assessment reports upon patient admission. Staff updated these whenever an incident occurs, other than that they are reviewed every six months in line with patients' care programme approach (CPA).
- Patients had regular set times when they would have a cigarette. Staff closed the downstairs of the ward following the final break at 10pm.
- Patients could use mobile phones on the ward.

Track record on safety

- The ward had two serious incidents requiring investigation in the last 12 months. One of these was with regards to an allegation by one patient against another and the other with regards to violence on the ward.

Reporting incidents and learning from when things go wrong

- All staff knew how to report an incident using the service's incident reporting system. Most staff knew of

Forensic inpatient/secure wards

what constituted a reportable incident. However, some staff were not clear on what constituted a reportable incident. Some staff referred to incidents involving patients, which they had not reported. For example, when a patient locked a member of staff in their room.

- After staff completed an incident form, they entered it onto the corporate computer system. In the three months from 1 July 2015 to 30 September 2015 there had been 32 incidents reported on the Springs Unit.
- Staff were aware of the need to be open and transparent and explain to patients when things went wrong.
- Staff received feedback from incidents in monthly team meetings. Overviews and clinical governance meeting minutes were also available on the shared drive.
- Staff were offered feedback after incidents and met to debrief. However, some staff noted that following a recent incident on Springs wing, this had not taken place for a week.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement 

Assessment of needs and planning of care

- Staff completed appropriate assessments on physical and mental health after admission. Following admission, staff completed an initial nursing assessment and more detailed care plans.
- Occupational therapists completed occupational self-assessment (OSA) and Model of human occupation screening tool (MOHOST). Where appropriate, they would also complete kitchen, road safety and sensory assessments.
- If a patient did not have a formal medical diagnosis, staff completed 'Autism Diagnostic Observation Schedule' and 'Autism Diagnostic Interview-Revised' assessments.
- Staff had not completed some records monitoring patients' weight and vital observations. Staff told us this was due to patients not being available or refusing. On

one record, staff had not updated monitoring a patient's weight since July. Prior to this they had refused. No assessment had been made of their capacity to make this decision.

- Staff produced a range of care plans for each patient covering the holistic needs of patients. This included care plans for 'my mental health problems,' stopping my problem behaviours', 'getting insight', 'my life skills', 'my relationships', and 'staying healthy'.
- All six care records we reviewed were personalised to the individual patient's needs.
- Five out of the six care records were up to date and showed a range of care plans to meet identified needs. However, for one person the plans were not clear what the goal of the admission was and how they were supporting the person's recovery.
- Each patient had an identified keyworker. The service had an expectation that the keyworker would meet the patient for a one-to-one discussion at least weekly and record this in the patients care files. In all the care files we reviewed there were few records of formal one-to-ones. For example, one patient only had two recorded and another had none.
- The provider stored patients' care records in paper files and locked these in the ward office. Some staff told us they found it difficult to locate information on the paper files. When staff updated care plans, they printed a copy and placed it in the patient's file.

Best practice in treatment and care

- Staff offered a range of psychological therapies recommended by NICE guidelines including cognitive behavioural therapy (CBT), mindfulness and dialectical behavioural therapy (DBT).
- The patients had access to health checks. Where a health check identified that a patient required physical healthcare the patient was then referred to the local GP. Staff confirmed that all patients, regardless of which part of the country they had come from, were registered to the local GP. Staff made appropriate referrals to physical health specialists.
- Staff completed health of the nation outcome scales for patients upon and throughout admission to measure outcomes.

Forensic inpatient/secure wards

- The wards completed various audits including patient satisfaction, health and safety, clinical records, medicines management, infection control, physical healthcare and health and safety.

Skilled staff to deliver care

- The ward had a range of mental health disciplines providing input. This included a ward doctor, an occupational therapist, nursing staff and assistant psychologists. A clinical psychologist, a consultant psychiatrist and a pharmacist also spent time on the ward.
- The ward did not have a social worker and was in the process of recruiting for a vacant gym instructor position.
- Staff received regular supervision. The manager told us they aimed to have formal supervision every four weeks. Ninety three percent of staff had received formal supervision in the month before the inspection.
- Ninety-three percent of staff had received a formal appraisal in the previous year.
- The ward had staff meetings. The ward aimed to have these once a month, although staff had no team meeting in July and August 2015.
- Staff had only received limited specialist training in learning disabilities, autistic spectrum disorder and autism. The clinical psychologist had recently provided a half-day session on autistic spectrum disorder awareness and management to improve staff knowledge. However, five members of staff told us they did not feel the training was sufficient for staff without prior experience or knowledge. Bank staff said they had not completed any autism training. Some staff had completed autism diagnostic observation schedule (ADOS) training externally. However, the majority of these staff included doctors, OTs and psychologists. Only one qualified nurse completed this training. Previous autism training records were dated from 2007 – 2010.
- Specialty doctors completed annual mandatory training as well as in-house training programmes including the recovery star, START assessment. Each doctor completed annual appraisals with their supervising consultant and regular supervision. Cygnet's group medical director manages the revalidation process centrally.

Multidisciplinary and inter-agency team work

- Staff from all professional backgrounds felt other members of the team respected their views.
- The ward held a weekly ward round when the MDT met to discuss patients. Staff from a range of professional backgrounds attended this. In the meeting we observed all staff could offer their professional perspective and view.
- Staff conducted a handover between shifts, which they recorded. Some staff told us they felt that communication could be improved between the team.
- External stakeholders spoke positively about the relationship they had with the hospital, who provided regular updates on patients. They told us staff were professional, communicated effectively and included both patients and their family/carers in their treatment pathway.

Adherence to the MHA and the MHA Code of Practice

- Eighty seven percent of the staff on the ward had completed their training in the MHA. The MHA administrator could provide additional mentoring and support to staff for any queries regarding the MHA.
- Staff completed consent to medication forms.
- Staff recorded dates for patients S132 rights to ensure staff remembered when to repeat them.
- Staff filled in detention paperwork correctly. All patients had their legal status, and dates for renewal, recorded.
- Staff made referrals to second opinion appointed doctors where appropriate.
- An advocate visited the ward every Thursday, or at other times if requested.
- Cygnet Hospital Harrow maintained a database on patients' MHA details including their MHA status, date of section and expiry, consent to treatment and dates of tribunals and hearings. The provider had an integrated governance and integrated audit meetings every other month that included monitoring MHA compliance. All of Cygnet's MHA administrators met at MHA governance meetings twice a year to evaluate current practices and discuss updates to the MHA.

Good practice in applying the MCA

- Although staff completed training in the MCA, their knowledge of the MCA was variable. It was not always

Forensic inpatient/secure wards

clear how they were supporting patients to make relevant decisions. Staff had not always recorded that they had assessed an individual's capacity to make a decision when it had been necessary to do so.

- We saw a completed capacity assessment for a patient regarding budgeting and managing their own money.
- Staff said that they could obtain advice and guidance on the MCA from Cygnet's company solicitors. They also said that the same solicitors provided their MCA training.

Are forensic inpatient/secure wards caring?

Good 

Kindness, dignity, respect and support

- Staff discussed patients in a respectful manner, for example during the MDT ward round which we observed.
- We observed staff interacting in a friendly and professional way with patients.
- The six patient we spoke with said that staff were polite and kind and that they felt happy on the ward and with the activities they accessed in the community.

The involvement of people in the care they receive

- Patients received an information guide when they arrived on the ward.
- Staff invited patients to attend ward round meetings.
- Staff sought to involve patients in developing care plans. All six care files showed some patient involvement in their development. Most patients had signed their care plans.
- The ward had a carer's group that met on a quarterly basis. Carers of patients on the ward were positive about the care the patients received and the staffing. Most felt involved in the patient's care, although one carer said that communication from staffing could be improved.
- Where appropriate, staff involved families and carers in patients' care. For example, during the MDT ward round staff contacted a relative of a patient who was involved in their care.

- The ward held regular community meetings every Monday morning. The most recent meeting gave patients an opportunity to discuss advocacy, catering and housekeeping.
- Staff involved patients in devising new menus and decisions regarding the decoration on the ward including the sensory room.

Are forensic inpatient/secure wards responsive to people's needs? (for example, to feedback?)

Good 

Access and discharge

- NHS England place patients in the unit. The placements came from all over southern England, including Kent, London, Devon and Wessex areas. Following a referral to the Unit staff completed a gatekeeping assessment within two weeks to see whether the person was appropriate for the unit. However, four members of staff told us they felt that some patients had too high needs for the unit. They told us this affected their ability to meet the needs of the patients. For example, staff had been required to maintain one-to-one observations for one patient for over two months.
- Of the 14 patients on the ward, three had been admitted to the ward in 2011 or earlier. The Unit had admitted 10 patients since 2014. Staff completed CPA reviews and discussed discharge planning at MDT reviews.
- When the service had agreed funding with a person's local clinical commissioning group (who fund non-low secure care) and it was appropriate, patients had moved to the less-restrictive Springs Wing. Other patients moved to units nearer their home area.
- In the six months prior to the inspection there was one delayed discharge from the unit. This was due to lack of suitable local community facility for the patient.
- The bed occupancy on the unit was 100%.
- Staff had regular communication with the patients' referring home trust and liaised with bed managers, care coordinators and home treatment teams to manage discharge. Relatives, carers and care coordinators were invited to ward round meetings and occasional staff from the patient's home Trust's discharge team also attended. Staff from the patient's

Forensic inpatient/secure wards

home Trust's crisis or home treatment team communicated with the patient prior to discharge. The ward staff faxed discharge notifications to the crisis or home treatment team and patient's GP before the patient was discharged including information about their medication.

The facilities promote recovery, comfort, dignity and confidentiality

- The main entrance to the upstairs of the ward was through the main bedroom corridor. At the time of the inspection, one patient was being nursed on one-to-one observations. This meant staff sat outside his door. This did not allow for privacy or dignity as other patients and visitors to the ward had to pass the open door.
- The ward board, displaying the names of patients and other details regarding them was in the ward office. However, other patients could view patients' details through the door.
- The ward was not autism friendly. The ward did not have visual signs to help people around the ward. There was one small sensory room, which had some equipment. Staff told us they found it difficult to support some patients with autistic spectrum disorder because the layout of the ward made it difficult to reduce noise.
- The ward had an occupational therapy room, which included a kitchen. The ward also had a sensory room and two other rooms where patients could meet people in privacy.
- The ward had an activity room, which was also the gym. This room contained a pool table and some gym equipment. However, at the time of the inspection the room was not fully in use due to ward renovations.
- There was a computer room with two computers, which patients could access with staff for supervised internet access.
- The ward had a telephone that patients could use.
- The patients had access to a large garden to the rear of the ward.
- Most patients told us they felt the food was good.
- Patients could personalise their bedrooms with their own possessions.
- The ward had a central locked cupboard where patients could store their possessions securely. Patients also had their own lockers. Staff risk assessed whether patients could have their own key to lock their bedrooms. Staff could lock their bedroom doors.

- Patients had access to a range of therapeutic activities including daily relaxation sessions, art club once a week, pet therapy twice a week and library trips. Some patients also completed one-to-one cooking sessions and swimming sessions.
- Four members of staff told us they felt the main way the ward could improve would be by offering more educational opportunities for the patients.

Meeting the needs of all people who use the service

- The service had produced some information in accessible formats. For example, one patient had a pictorial plan regarding his expressed plan of moving on.
- The service could provide food that met religious needs, such as being halal.
- The ward had a prayer room. Staff completed a care plan regarding the spiritual needs of patients. A chaplain would visit the ward if requested.

Listening to and learning from concerns and complaints

- Patients knew of how to complain and give feedback. Staff responded to minor individual concerns appropriately.
- In the last year, the Springs unit had received two complaints. Staff had investigated and responded to these appropriately.

Are forensic inpatient/secure wards well-led?

Good 

Vision and values

- Staff identified 'helpful, respect, empathetic' as values which are in line with organisation's values.

Good governance

- The ward completed regular audits in case notes and care plans.
- The service had an integrated governance meeting every two months. The agenda for these had changed recently. The regular agenda now included medication management, risks, restraints, physical interventions, security and recent audits.

Forensic inpatient/secure wards

- Each ward had a recently implemented overarching local action plan (OLAP) that included health and safety, quality network reviews and the service environment. These areas were red, amber and green (RAG) rated, updated monthly and included recommendations, the accountable person, resources required and action plans. Some actions were also allocated to the local risk register. The hospital manager trained the heads of departments on using the OLAP to ensure information filtered down to team meetings.
- Cygnet's main office completed recruitment including interviewing and employment checks. The hospital manager could set criteria for shortlisting and participated on interview panels. Staff records were up to date including occupational health, references, work permits, proof of identification and professional memberships. The ward had experienced a high turnover of staff in the previous year and did not have a strategy in place to address staff retention.
- Cygnet Harrow's hospital manager reported to the operations manager, who reported to the organisations chief operating officer. The hospital manager attended regular meetings with other Cygnet hospital managers from other sites for information sharing.
- The quality assurance manager acted as a link between the local governance and corporate governance and covered eight Cygnet sites across the south west and south east of the country.

Leadership, morale and staff engagement






- Staff felt well supported by management and felt that the ward team worked well together. They felt respected by other staff members. Most staff told us that they felt the morale of the team was good.
- Staff felt they would be able to raise a concern should they have one.
- The Springs unit had a sickness rate of 1.5% between 01 September 2014 and 31 August 2015.
- Staff were able to feed their views back through the survey of staff conducted by the provider.
- The hospital had a whistleblowing policy and “speak out” helpline staff could access. One incident of bullying had been investigated appropriately.

Commitment to quality improvement and innovation

- The Springs unit is a member of the Royal College of Psychiatry Quality Network for forensic mental health services.

Long stay/rehabilitation mental health wards for working age adults

Good 

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

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

Good 

Safe and clean environment

- Most of the layout of the ward enabled staff to observe most areas. However, the ward had certain areas which were difficult to observe due to being out of direct lines of sight.
- Patients left the ward down a staircase and along a corridor within Byron ward. This route took them out of sight of Springs wing staff. As some Springs wing patients could leave the ward unescorted, they could come into contact with Byron patients away from the sight of Springs wing staff. Byron ward staff were not always present on the corridor used by Springs wing patients. The entrance to Springs wing was open and therefore accessible by Byron ward patients. This situation created a risk of patients from different parts of the hospital coming into contact out of the sight of staff. The provider had not taken steps to mitigate these risks. Following our visit, the hospital manager provided proposed refurbishment plans that involved relocating Springs wing to a new unit on the hospital site and would allow separate entrances for each ward. The refurbishment work is due to start in the spring of 2016 with an aim to be completed in July 2017.
- The ward had potential ligature points, including handles on the doors of patients' rooms. Following a recent health and safety audit identifying these

potential risks, the provider was due to replace the doors and hinges in the few weeks following our inspection. The new doors will also be fitted with piano hinges. In the meantime, staff managed this risk was through observation and risk assessments.

- The ward area was clean and well-maintained. However, one of the patient's bathrooms had damp around the sink. In that damp area the wall was covered with mould. This could have a negative impact on patients' health. After we pointed this out, staff work began on removing the mould from the wall.
- Each patient's room contained an ensuite bathroom with a shower cubicle. The staff identified the cubicles as potentially unsafe as they are too small for some patients. There were plans in place to replace the shower cubicles with wet rooms.
- Staff adhered to infection control principles. The ward had hand washing facilities available throughout, including by the entrance.
- Staff completed environmental risk assessments on a quarterly basis.
- Each member of staff carried an alarm. The ward also had a radio for staff members to contact staff on other wards if they needed assistance.

Safe staffing

- A qualified nurse and healthcare assistant both staffed the ward day and night. The staffing numbers on the ward provided for one qualified nurse on the ward at all times.
- At the time of our visit, there was one vacancy for a qualified nurse. This position was to work the shifts not covered by the current qualified member of staff.

Long stay/rehabilitation mental health wards for working age adults

Good 

- In order to maintain one qualified member of staff on the ward, the ward regularly employed a qualified bank nurse. The ward never used agency staff. In the event that management could not obtain a qualified bank nurse, they would move a qualified nurse to the wing from another part of the hospital.
- In the previous 12 months the sickness rate for qualified nurses was 8.5%. For unqualified staff the sickness rate was 5%. In the previous 12 months one staff member had left the ward.
- The provider calculated staffing levels according to what had been historically used on the ward and used a staffing matrix based on patient numbers.
- The ward employed bank workers wherever possible that had worked on the ward before to ensure continuity of care for patients.
- The ward manager was also the manager for Springs unit. This meant they could adjust staffing levels as required by moving the staff between the two wards. This was sometimes necessary where extra staff were required on the wing to facilitate activities such as escorting patients out into the community. Staff planned these activities to ensure the manager could make the necessary staff adjustments. However, another staff member told us that it was common for planned activities to be cancelled because there were not always enough staff to escort patients from the ward out into the community. There was no information available as to how many activities the ward cancelled. However one staff member said this was a common occurrence. Planned activities are an important part of patients' rehabilitation. Therefore frequent cancellation of activities could potentially undermine patients' rehabilitation. Patients told us that their leave was not cancelled because of staff shortage, although the time of was sometimes changed for this reason. However most leave from the wing was unescorted.
- A qualified nurse was often present in the communal areas of the wing, but this was not the case at all times. This was because staff were sometimes involved in other duties.
- Staff told us that there were enough staff on the wing to ensure that patients had regular 1:1 time with their named nurse. Patients confirmed they regularly spent time with their nurse.

- If physical interventions were required on the ward, staff used the panic alarm system to summon assistance from other wards of the hospital. All staff on the ward, including the manager, had completed physical restraint training.
- Out of 26 mandatory training courses, staff had completed 24. In the remaining two courses for Clozapine Dose Titration and Prescription Writing the completion rate was 50% for one member of staff.

Assessing and managing risk to patients and staff

- In the past six months, no patients had been in long-term segregation or seclusion. During this time, staff restrained four patients. None of these restraints was in the prone position. Staff had not used rapid tranquilisation. There was no seclusion unit on the ward. If a patient experienced a significant deterioration in their mental health, they could be transferred to the low-secure unit adjacent to the ward.
- Staff completed risk assessments after every incident and updated the patient's risk profile.
- Staff used two recognised risk assessment tools. The first was the short term assessment of risk and treatability (START) risk assessment. Staff used this tool to assess all the patients on the ward. In the eight risk assessments we looked at, all were fully completed and the information carried over into each patient's care plan. This was in order to plan how to manage and decrease the risk for each patient. For example, one risk assessment identified that a patient was at risk of self-neglect. Staff recorded this risk in the patients' care plan along with steps as to how staff would support greater insight and self-care. The second risk assessment tool that staff used was historical, clinical risk assessment (HCR-20). This was not used in every case and only where patients had a history of violence and aggression. These were properly completed and the information translated to the patients' care plans.
- Staff told us that informal patients were free to leave at will. Informal patients confirmed this. Staff also gave informal patients a leaflet detailing their rights and how staff would treat them while on the wing. The patient and a nurse signed this leaflet. The leaflet said that informal patients could only leave the hospital grounds 'with the consent and agreement of the nursing staff/responsible Clinician'. There was a risk that by providing information in this form, informal patients may not be fully aware of their rights to leave the hospital at will

Long stay/rehabilitation mental health wards for working age adults

Good 

- Staff used verbal de-escalation techniques prior to restraining patients.
- In the past 12 months, staff had not put any patients into seclusion or given any patients rapid tranquilization.
- Staff training records showed that all staff members had completed their mandatory safeguarding training and were up to date with mandatory refresher courses. Staff demonstrated a good knowledge of safeguarding procedures.
- The ward did not permit child visitors. Patients could see child visitors away from the ward in another part of the building.
- The provider had appropriate arrangements in place for obtaining medicines. Staff told us how medicines they obtained and supplies were available to enable patients to have their medicines when they needed them. We checked the medicines for 33 patients and saw no medicines were out of stock.
- The provider stored medication securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use.
- The provider stored and managed controlled drugs appropriately. It was the provider's policy to store and record the use of all benzodiazepines in its register of drugs liable for misuse.
- The provider had appropriate arrangements in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving patients their medicines were recorded.
- The provider had weekly visits by a pharmacist who checked staff gave medicines safely to patients and recorded the administration of medicines correctly. Staff checked MHA compliance, prescription writing and patient details.
- On Springs wing, the ward manager said nursing staff labelled and dispensed to take away medicines for

patients to use on weekend. This did not comply with the provider's medication management policy which stated all leave medicines should be ordered from the pharmacy.

- Medicines in the emergency resuscitation packs were fit for use. However, none of the wards had any flumazenil injection available, which is used to reverse the central sedative effects of benzodiazepines. As lorazepam injection was used for rapid tranquilisation a risk assessment is required to determine if this should be available to treat patients if they experienced respiratory depression. Staff on Byron ward and Springs unit told us they would order some from pharmacy that day.
- Patients who staff recorded as being administered lorazepam injection for rapid tranquillisation had appropriate records on their rapid tranquillisation observation charts.

Track record on safety

- There were no serious incidents recorded on the wing in the past 12 months. Staff recorded one adverse event when a patient had gone absent without leave.

Reporting incidents and learning from when things go wrong

- Staff demonstrated a good knowledge of how to report incidents that took place on the ward. We saw one example of this where a detained patient had left the ward without permission, before returning two hours later with police. Staff had fully documented this incident with action plans put in place to prevent a further occurrence.
- Management on the wing told us that they gave staff information from incidents handovers, ward rounds and debriefings following incidents. Staff we spoke to confirmed this happened. However, staff also said that a reflective practice meeting that used to take place over a year ago no longer happened.

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

(for example, treatment is effective)

Long stay/rehabilitation mental health wards for working age adults

Good 

Requires improvement 

Assessment of needs and planning of care

- Staff told us that they assessed each patient for risk and their care needs upon admission to the wing. However, it was not always possible to see what actions had taken place on a patient's admission as staff archived older care plans. Of the eight patient files we saw all contained risk assessments that staff completed upon the admission of the patient.
- We looked at eight patients' records. Staff recorded where they had examined patients' physical health. However, staff had not done this in a systematic or regular way. Staff said that all patients received a physical examination on a weekly basis by the ward doctor. In three of the eight records there was no indication that this had happened.
- Patient care plans were detailed with multiple objectives with a recovery focus. All the plans that we saw had indications of patient involvement. Such objectives included addressing mental health recovery, making feasible plans, developing relationships and staying physically healthy. For example one care plan of a patient with a history of shouting and biting detailed how staff planned to speak softly and calmly at all times to encourage calmer behaviour. The plan also detailed how staff planned to remove the patient from others during incidents of anxiety and offer therapies at the same time.
- The ward kept patient files on paper but not electronically. These paper files did not hold all the information about the patient. This was because from time to time staff removed and archived older records. The archived files were held in a different part of the building.

Best practice in treatment and care

- The patients had limited access to health checks. Where a health check identified that a patient required physical healthcare the patient was then referred to the local GP. Staff confirmed that all patients, regardless of which part of the country they had come from, were registered to the local GP. However, staff admitted that they did not automatically address health concerns

raised by health checks. They gave two examples. In the first they referred a patient with repeated very high blood pressure a local GP who declined to prescribe any treatment. In this case, staff decided that they would write to the GP to raise their continuing concerns, but would not give any physical health treatment themselves. In the second case, a patient with continuing high cholesterol was similarly referred to a GP because the ward doctor was not confident in prescribing any treatment.

- Psychology sessions aimed to give patients an insight into their illness and strategies for coping with their symptoms. Psychology also provided sessions in anger management and cognitive behavioural therapy.
- The wards completed various audits including patient satisfaction, health and safety, clinical records, medicines management, infection control, physical healthcare and health and safety.

Skilled staff to deliver care

- A range of professionals were available to support patients on the wing. This comprised of a qualified nurse, an occupational therapist and a ward doctor who worked solely on the wing. In addition a psychologist, a social worker and a pharmacist visited the wing to provide additional support.
- Staff confirmed that they received supervision every four to six weeks and described this as helpful and supportive. Staff also received clinical supervision when required and a yearly appraisal. However, reflective practice was not currently available for staff. A reflective practice meeting has not taken place for staff on the wing for over a year. The minutes of the staff meeting in September showed that they mostly discussed staff administration.
- The nurses and healthcare support workers did not have a specialist background in autism. The clinical psychologist had recently provided a half-day session on autism spectrum disorder awareness and management to improve staff knowledge. The nurse received this training only after two and a half years on the ward, although during this period received mentorship from a nurse experienced in autism. Some hospital staff had completed autism diagnostic observation schedule (ADOS) training externally.

Long stay/rehabilitation mental health wards for working age adults

Good 

However, the majority of these staff included doctors, OTs and psychologists. Only one nurse completed this training. Previous autism training records were dated from 2007 – 2010.

- Specialty doctors completed annual mandatory training as well as in-house training programmes including the recovery star, START assessment. Each doctor completed annual appraisals with their supervising consultant and regular supervision. Cygnet's group medical director manages the revalidation process centrally.

Multidisciplinary and inter-agency team work

- Daily handovers took place between day and night staff. Information passed between the staff concerning the patients was detailed in the patients' notes.
- Staff described that they work effectively with the outside agencies, including the local authority, police and GP services to support patients on the wing. However, there was no available evidence to indicate the effectiveness or otherwise of such relationships.
- External stakeholders spoke positively about the relationship they had with the hospital, which provided regular updates on patients to them. They told us staff were professional, communicated effectively and included both patients and their family/carers in their treatment pathway.

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

- 100% of the staff on the ward had completed their training in the MHA. However, the information leaflet given to informal patients regarding their right to leave the hospital showed that informal patients may not be fully aware of their right to do so.
- We found staff ensured patients understood the provisions of the MHA that applied to them and their rights to appeal to the tribunal when under the MHA and when their section was renewed. We did not find evidence that this was carried out on other occasions.
- Staff said they informed all patients of their rights under the MHA and documented this in patients' files. However, the three files we inspected did not all contain a record of patients being given their rights. One patient we spoke to confirmed staff told them their rights.

- Patients had access to an advocate who visited the ward regularly. The advocate confirmed that staff were supportive of advocacy and regularly referred patients requiring support to the advocacy service.
- We found that assessments of capacity to consent to treatment were not carried out on a regular, systematic basis.
- There was a patient whose medication change was waiting to be authorised by a second-opinion appointed doctor. The required paperwork was not completed in a way that complied with the MHA.
- The MHA administrator could provide additional mentoring and support to staff for any queries regarding the MHA.
- Cygnet Hospital Harrow maintained a database on patients' MHA details including their MHA status, date of section and expiry, consent to treatment and dates of tribunals and hearings. The provider had an integrated governance and integrated audit meetings every other month that included monitoring MHA compliance. All of Cygnet's MHA administrators met at MHA governance meetings twice a year to evaluate current practices and discuss updates to the MHA.

Good practice in applying the MCA

- All staff completed training in the MCA and could describe the five principles of the MCA.
- The staff had not made any applications for Deprivation of Liberty Safeguards in the past 12 months.
- Staff on the ward knew of the policy developed by Cygnet relating to the MCA. Reading the MCA is part of their mandatory training. It was also available for staff to read on the staff database.
- Staff said that they could obtain advice and guidance on the MCA from Cygnet's company solicitors. They also said that the same solicitors provided their MCA training.

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

Good 

Kindness, dignity, respect and support

Long stay/rehabilitation mental health wards for working age adults

Good 

- Staff treated patients in a kind and respectful manner. For example, one nurse spoke at length with a patient about their future education and career plans and providing advice as to how to reach those goals.
- Patients said that staff treated them in a respectful way and cared for their health and dignity. Patient spoke positively about their experiences of being on the ward.
- Staff showed an understanding of how they should speak to and care for patients. Each patient's file had a communication protocol detailing how staff should interact with patients.

The involvement of people in the care they receive

- The patients received a detailed booklet upon admission to the ward describing the support they could receive as well as summarising their rights. The guide included information about the purpose and routines of the ward, who the key members of staff were, details of the treatment that is offered, a list of activities available, and details of how to complain about the service and how to contact the CQC.
- The majority of care plans evidence patient involvement and gave clear indications of patient desires and concerns. The two patients we spoke to confirmed that they had regular involvement in their care planning.
- The ward advertised the mental health advocacy service on the patient notice board on the ward. The advocate confirmed that they regularly supported patients with a range of issues on the ward. This included attending ward rounds where they supported patients to ask for leave or to raise issues in relation to discharge. One patient said he was frustrated by the difficulties they had contacting their social worker and commissioning authority to progress the arrangements for his discharge and return to his home area.
- The ward held a weekly community meeting for patients to discuss issues of concern and to receive information from staff. The patients confirmed this meeting could be useful and said that staff always reminded patients in these meetings that they could make a complaint.
- Patients told us about groups and activities including cookery, art groups, creative writing groups and a cultural awareness group. One patient said that he had leave each week to attend a college where he was studying a maths course with a view to going to

university. One patient said that he would like there to be more activities at weekends because there was a lot of sitting around and that time went very slowly when there was nothing to do.

- Patients spoke positively about leave to the community. They told us about regular trips with small groups of patients to the local shops and trips out for coffee. One patient enjoyed going bowling.
- Patients felt involved in decisions about their care and treatment which mainly took place through discussions with their doctor at ward rounds. Patients also felt that the care and treatment they received was helpful to them in managing the effects of their autistic spectrum disorder. One patient said that staff prompted him to have a shower and to shave, which he would often forget to do. Another patient said that their discussions with their psychologist had given them a much better understanding

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

Good 

Access and discharge

- The average bed occupancy rate in the past six months was 90%.
- Either the NHS or the local Clinical Commissioning Group funded all beds on the wards. None of the beds were privately funded or were contracted out at the time of our visit.
- A bed was always available for a patient when they returned from leave. This was because of the rehabilitation nature of the ward. Staff always planned admissions well in advance so there were never any cases of a lack of beds. The ward did not provide for emergency admissions.
- Staff did not move patients between wards on admission. With rehabilitation the plan was always to admit the patient and remain on the ward until they were ready for discharge.

Long stay/rehabilitation mental health wards for working age adults

Good 

- Staff always planned discharges well in advance as part of a patient's transition plan, to take place during the day.
- Emergency beds were available in other parts of the location in the event of a patient becoming unwell.
- Discharge for some patients on the ward was sometimes delayed, mostly because of housing problems. The average delay for this reason was two months.
- A typical length of stay on the ward was about two years. Patients were usually discharged to supported living in the community.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had a variety of facilities for patients. This included a therapy room, an occupational therapy room, a lounge, a kitchen with patient washing facilities and a computer area. The kitchen was fully equipped and patients were encouraged to do their own washing. In the lounge there was a television, a DVD player with DVDs and a games console with games. The ward had a computer with a printer for the patients to use. All equipment was in working order.
- There was no dedicated room on the wing for patients to meet visitors. Private rooms were available on the ground floor for this purpose.
- Patients could keep and use their own mobile phones on the ward for making private calls.
- The hospital had two gardens for patients to use. The one beside the ward was relatively large and well-maintained with plants and seating areas.
- The kitchen area on the ward was for the patients' use. They could make hot and cold drinks whenever they wanted and there was also a water dispenser. Patients said that the quality of the food was variable. One patient said that the portions could be bigger. The ward manager said that consideration had been given to this comment and, following discussions with the kitchen and a dietician, the food portions for that patient were increased.
- Patients' bedrooms were personalised with personal items such as book and games and musical instruments. Some patients also had their own bedding. Each room had storage space for patients' possessions.

Meeting the needs of all people who use the service

- Access to the ward was via a set of stairs only and the staff were aware of the impact for patients who were referred with reduced mobility.
- The ward displayed a range of information for patients. This included details about an advocacy clinic, the meeting minutes for the last patient community meeting, multi-faith pastoral care and a charter describing what patients could expect from the service.
- We did not see leaflets on the ward in other languages. Staff said that they had access to translation services including staff at the location who could speak a range of community languages.
- There was a reasonable range of food available for patients. Patients said that the quality and choice of food was generally good. However, one patient said that he would like to have more vegetables. The staff said that a range of alternative food was available for religious and ethnic groups as well as gluten-free meals. At the time of our visit, such food was not on the menu, although staff said it could be prepared at patients' request.
- In a communal area outside of the ward there were faith rooms for patients to use where they could receive appropriate spiritual support. These rooms also contained religious and spiritual reading material from different faiths. One of these rooms was also used as an advocacy office where patients could meet the advocate in private.

Listening to and learning from concerns and complaints

- The patients we spoke to confirmed that they knew how to make a complaint if they needed to. One patient said that staff repeated how to do this every Monday at the patients' community meeting.
- Staff said that complaints on the ward were very rare and that no patients on the ward had made a formal complaint for over the last year. The patients we spoke to confirmed that they had not made any complaints and did not know of any others being made. The advocate also said that they were not aware of any formal complaints on the wing for a very long time. The advocate said that occasionally patients were not happy about the scheduling of their leave and asked for their support to request it being moved. The advocate said

Long stay/rehabilitation mental health wards for working age adults

Good 

that staff usually agreed to these requests. A patient also confirmed that staff had responded positively to their request to move their scheduled leave times to accommodate his needs.

- Staff said that feedback was given to staff and patients following an investigation into a patient's complaint. However, no patient records displayed any such feedback.

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

Good 

Vision and values

- It was evident that the staff knew who the senior managers of the ward were and these managers were on the ward throughout our inspection. The managers worked in offices adjacent to the ward and were clearly accessible to staff.

Good governance

- Records indicated that staff were mostly up to date with their mandatory training and that they received regular supervision. Although staff had not received significant training in working with an autistic client group.
- Staff said that they learned from incidents through staff meetings, handovers and ward rounds. However, the reflective practice meeting was stopped over a year ago. The minutes of the staff meeting in September detailed only discussions on administrative issues. There was no discussion of cases, how staff worked with patients, patients' needs or reflective practice.
- Staff did not have the ability to submit items directly to the trust risk register. Staff gave details of incidents to a security manager, who had the responsibility of updating the register. It was not clear who had this responsibility in the absence of the security manager.
- Each ward had a recently implemented overarching local action plan (OLAP) that included health and safety, quality network reviews and the service environment. These areas were red, amber and green (RAG) rated, updated monthly and included recommendations, the accountable person, resources required and action

plans. Some actions were also allocated to the local risk register. The hospital manager trained the heads of departments on using the OLAP to ensure information filtered down to team meetings.

- The clinical manager chaired a monthly clinical governance meeting that discussed topics such as a corporate learning log, incidents, complaints, and pharmacy. Doctors, nurses, the pharmacist, quality assurance manager and medical director attended these meetings.
- Cygnet's main office completed recruitment including interviewing and employment checks. The hospital manager could set criteria for shortlisting and participated on interview panels. Staff records were up to date including occupational health, references, work permits, proof of identification and professional memberships.
- Cygnet Harrow's hospital manager reported to the operations manager, who reported to the organisations chief operating officer. The hospital manager attended regular meetings with other Cygnet hospital managers from other sites for information sharing.
- The quality assurance manager acted as a link between the local governance and corporate governance and covered eight Cygnet sites across the south west and south east of the country.

Leadership, morale and staff engagement

- The ward did not have any bullying or harassment cases in the past 12 months.
- Staff said that they felt confident that they could raise concerns about their work with management.
- Staff said they enjoyed working on the ward and their morale was good. One staff member said that management had been very supportive of staff, giving the example of management agreement to staff requests for flexible working.
- One staff member said that management were very supportive in staff ideas for new patient activities. One of these ideas was for a patient swimming group, which was shortly to be implemented.

Commitment to quality improvement and innovation

Long stay/rehabilitation mental health wards for working age adults

Good 

- The consultants said a lot of work had gone into trying to get AIMS accreditation but they had been let down by the environment. Work was currently underway on the wards to address the recommendations and improve the environment.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that all staff on Springs wing and Springs unit complete specialist autism training to better understand the needs of patients.

Action the provider **SHOULD** take to improve

- The provider should ensure that it considers the risks of the shared entrance between Byron ward and Springs wing by putting measures in place to ensure patients' safety and effectively manage risks.
- The provider should review Springs unit ward environment to ensure it meets the needs of people with autism and/or learning disabilities.
- The provider should ensure that the ward board cannot be viewed from the ward on Springs unit.
- The provider should ensure that all areas of the ward are kept tidy and clear of broken or unused items of equipment at all times.
- The provider should ensure that blind spots on Springs wing are addressed and staff mitigate associated risks.
- The provider should ensure that staff follow hand hygiene procedures.

- The provider should ensure that they complete a risk assessment to determine if flumazenil should be available to treat patients if they experienced respiratory depression.
- The provider should ensure that staff report all incidents.
- The provider should ensure they give informal patients accurate information regarding their rights to leave the ward.
- The provider should ensure that staff assess the capacity of patients to make individual decisions in relation to the MCA.
- The provider should proactively review whether it is meeting the needs of patients who have been on the unit for more than five years.
- The provider should ensure that supervision on Byron ward takes place each month for all staff and that this is recorded clearly.
- The provider should ensure that patients' information in their files is easily accessible, including archived information.
- The provider should ensure that patients' health needs are adequately addressed.

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

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider had not ensured that all staff on Springs unit and Springs wing had completed specialist autism training. This meant that staff were not adequately trained to understand and manage patients' needs.

This was a breach of regulation 18 (2)(a)