Care Quality Commission

Cygnet Hospital Woking

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

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

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.

- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

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

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

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

- Staff from different disciplines worked together as a team to benefit patients.

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

- Staff supported patients to make decisions on their care for themselves proportionate to their competence. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

- Staff treated patients with compassion and kindness. They involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff informed and involved families and carers appropriately.Staff planned and managed discharge well.

- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity.

- The food was of a good quality and patients could make hot drinks and snacks at any time.

- The wards met the needs of all patients who used the service. Staff helped patients with communication, advocacy and cultural and spiritual support.

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

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

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Summary of findings

- Governance processes operated effectively at ward level and performance and risk were managed well. Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

  However:

- Some medicines for individual use were not labelled for individual patients as per providers own policy.

- Some Physical observations were not being recorded post rapid tranquilisation (RT)administration.

- On a few occasions patients had been secluded in their bedroom as the seclusion room was already in use. The seclusion was appropriately recognised and reported with the monitoring in place. However, staff were concerned about patient safety and sought support to ensure this arrangement had been considered.

- Some patients on Greenacre and Oaktree wards told us they did not always feel safe from other patients.

- The maintenance systems did not ensure issues like the broken lock to the de-escalation room were identified and repaired promptly. We raised the broken lock at the time of inspection and the provider arranged to have it repaired that day.

- Some staff did not know what to do if a fob(electronic locking system) system failed or the unit needed to be locked using another system.

- Managers did not ensure there were always lessons learnt in relation to incidents like medication errors.

- Staff on Picasso ward told us they relied on doctors' assessments for determining mental capacity whenever they identified an issue.

- There was inadequate provision of activities on evenings and weekends for patients on Picasso ward.

Summary of findings

Contents

Cygnet Hospital Woking

Good ●

Services we looked at

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

Summary of this inspection

Background to Cygnet Hospital Woking

Cygnet Hospital Woking is an independent mental health hospital run by Cygnet Surrey Limited.

The hospital offers a range of secure mental health services for men and women across four wards. The service has a sister hospital close by, Cygnet Lodge Woking, which provides a high dependency inpatient rehabilitation service for men and extends the care pathway. Cygnet Lodge Woking is inspected and rated as a separate location. The same leadership team and registered manager oversee both locations.

There are three core services at the hospital

- Forensic inpatient/ Secure wards (Greenacre and Oaktree ward)
- Acute wards for adults of working age and psychiatric intensive care units (Acorn ward)

- Long Stay/ rehabilitation mental health wards for working age adults (Picasso ward)

Cygnet Hospital Woking is registered to provide the following regulated activities:

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

There is a registered manager who has been in post since July 2018.

We have inspected this hospital 13 times since it was registered with the Care Quality Commission in November 2010. At the last inspection in February 2018,the service was rated good overall, and good across all the key questions.

Our inspection team

The team that inspected the service comprised four CQC inspectors, an inspection manager, a medicines inspector, and an assistant inspector and a variety of specialists: These included a specialist nurse with experience in long stay rehabilitation services, a specialist

nurse with experience of psychiatric intensive care units, a specialist nurse with experience of forensic mental health inpatient units and an expert by experience. Experts by experience are people with lived experience of using services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with the registered manager and managers for each of the wards;

Summary of this inspection

- spoke with 31 other staff members; including doctors, nurses, a psychologist, a social worker and an occupational therapist
- spoke with 20 patients who were using the service;
- looked at 27 care and treatment records of patients:

- carried out a specific check of the medication management on all of the wards and checked 10medicines records across the hospital;
- and looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients were overall positive about the support they received from staff during the day. They told us that staff were able to recognise when they required support and offered time on an individual basis to talk. But some patients on Greenacre and Oaktree wards told us they did not always feel safe after seeing other patients being aggressive on the wards.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated Safe as requires improvement because:

- The forensic inpatient/secure wards and long stay/ rehabilitation mental health wards did not always use systems and processes to safely store medicines. Some medicines were not always labelled correctly, for example one patient's eyedrops were not properly labelled.
- Post rapid tranquillisation records were not always completed adequately. Staff did not fully complete physical observation records fully at the time rapid tranquillisation was used.
- On Picasso staff did not always follow the infection control policy. We did not see staff on Picasso ward cleaning hands with hand gel and there was no handwashing sink that was easily accessible on the ground floor part of the ward.
- On a few occasions patients had been secluded in their bedroom as the seclusion room was already in use. The seclusion was appropriately recognised and reported with the monitoring in place. However, staff were concerned about patient safety and sought support to ensure this arrangement had been considered.
- The maintenance systems did not always ensure issues like the broken lock door to the escalation room in Greenacre ward were identified and repaired promptly.
- Some staff were not clear what to do if a fob (electronic locking system) system failed or the unit needed to be locked using another system.
- Managers on Greenacre ward did not ensure lessons there were always lessons learnt in relation to medication incidents to prevent a reoccurrence of the same medication incident

However:

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery.

Requires improvement 🟠

Summary of this inspection

- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records, which were both paper-based and electronic.
- Staff regularly reviewed the effects of medications on each patient's physical health.

Are services effective?   Good ●

We rated effective as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Summary of this inspection

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves proportionate to their competence. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

Are services caring?   Good ●

We rated caring as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.
- The hospital had a 'people's council' that comprised of service user representatives and senior managers as well as other clinicians. This council allowed patients to have a say in how the service developed.

However:

- Some patients on Greenacre and Oaktree wards told us they did not always feel safe from other patients.

Are services responsive?   Good ●

We rated responsive as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. All patients could keep their personal belongings safe. In all wards there were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.

Summary of this inspection

- The wards met the needs of all patients who used the service –including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Patients on Picasso did not have appropriate access to therapeutic activities at weekends or evenings.

Are services well-led?   **Good** ●

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Overall, staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Detailed findings from this inspection

Mental Health Act responsibilities

Staff explained to informal patients on admission that they could leave the ward freely.

Staff explained patients their rights under the Mental Health Act in a way they could understand and repeated it as required.

Staff on the ward had mandatory awareness training on the Mental Health Act. Staff were confident that they had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Patients had easy access to information about independent mental health advocacy. We saw information about independent mental health act advocacy displayed on both wards for patients and saw evidence that staff had supported patient's access to an advocate.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff on the ward had access to mandatory electronic training on the Mental Capacity Act.

Staff understood the principles of the MCA and we found reference to MCA assessments/best interest meetings in care records reviewed.

Staff assessed capacity to consent to treatment and admission on admission.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Forensic inpatient or secure wards	Requires improvement	Good	Good	Good	Good	Good
Long stay or rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

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

Good ●

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

Information about the service

Acorn ward is a 10 bedded, female only psychiatric intensive care unit. It has been open for a year and a half and there were nine out of the 10 beds currently in use by patients at the time of this inspection.

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

Requires improvement ●

Safe and clean care environments

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

Safety of the ward layout

- Staff completed and regularly updated thorough risk assessments of all wards areas, and removed or reduced any risks they identified. We saw fire risk assessments and checks for water quality had been completed appropriately.
- Staff could observe patients in all parts of the wards. Where blind spots had been identified, these were mitigated using convex mirrors and staff observation
- The ward complied with guidance from the Department of Health and there was no mixed sex accommodation.
- The ward only admitted female patients. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. We saw an up

to date environmental risk assessment that had high lighted the risks across a map of the ward. Staff had easy access to rescue equipment such as ligature (a cord used for the purpose of self-harm) cutters.

- Staff had easy access to alarms and patients had easy access to nurse call systems. Patient bedrooms had vision panels (with shutters to allow privacy) to allow observation. Staff were present throughout the communal areas of the ward to help patients raise the alarm if needed. We saw that these alarms were checked daily, and observed quick response when alarms were set off.

Maintenance, cleanliness and infection control

- Ward areas were clean, well maintained, well furnished and fit for purpose. Staff had identified that their external contractors had delayed fixing a broken lock on a door for months and so they had arranged to hold a contract review meeting to institute new timelines to ensure quick response to maintenance requests.
- Staff made sure cleaning records were up-to-date and the premises were clean.
- Staff followed infection control policy, including handwashing.

Clinic room and equipment

- Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- Medicines were stored securely. Doors were locked to clinic rooms with access restricted to appropriate staff.
- There was provision to store Controlled drugs (CD)securely. Staff monitored and recorded room and refrigerator temperatures daily. These were within the required range.

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

Good 🟢

- Unwanted medicines were recorded and disposed of appropriately. Regular checks of emergency medicines and equipment were carried out by staff and recorded. All medical equipment and medicines checked on the day of inspection were in date including oxygen.
- The clinics contained appropriate equipment including a blood pressure monitor, scales and hand washing basin.
- Staff checked, maintained, and cleaned equipment.

Safe staffing

Nursing staff

- The service had enough nursing and support staff to keep patients safe. We saw that on almost all shifts, staffing levels were meeting the unit's guidance and the manager of the unit had been able to successfully increase the staffing numbers to meet patients' needs.
- The service had no vacancies. The service had contracted agency staff to ensure they had enough qualified nurses and had over recruited healthcare support workers to ensure they could safely carry outpatient observations.
- The service had low rates of ad hoc bank and agency nurses and nursing assistants. For the three months before this inspection, there were no shifts filled with bank staff. In August 0.3% of shifts were covered with ad hoc agency staff, in September 1.6% of shifts were filled with ad hoc agency staff. This decreased to 0.3% of shifts being filled by ad hoc agency staff in October.
- Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.
- The service had reducing turnover rates. Three out of 12 permanent staff had left in the year before this inspection.
- Managers supported staff who needed time off for ill health.
- Levels of sickness were low. In October 2019 it was 1.4%which was a decrease from the previous month(September 2019) where it was 2.4%.•Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.
- The ward manager could adjust staffing levels according to the needs of the patients. The safer staffing levels had been increased to two registered nurses on the day and

night shift and three healthcare assistants on the dayshift and two at night. The manager put extra staff on the ward to complete the enhanced observations for patients that needed them to ensure there were enough staff on the ward.
- Patients had regular one to one sessions with their named nurse.
- Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. In the rare occasions where leave had to be cancelled, it was re-arranged.
- The service had enough staff on each shift to carry out any physical interventions safely.
- Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

- The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The ward had a dedicated consultant psychiatrist and a specialist doctor.
- Managers could call locums when they needed additional medical cover.
- Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

- Mandatory training completion rates ranged from 79%(infection control e-learning and safeguarding individuals at risk e-learning) to 100% (intermediate life support and automatic electrical defibrillator training. Staff who did not have up to date training were booked to complete it.
- The mandatory training programme was comprehensive and met the needs of patients and staff.
- Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff
Assessment of patient risk

- Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. They recently started using the short term assessment of risk tool (START). We reviewed the care records of three out of the ten patients on the wards and saw that staff had assessed patient risk appropriately.

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

Good ●

Management of patient risk

- Staff knew about any risks to each patient and acted to prevent or reduce risks. This included having occupational therapists completing falls risk assessments. Risks were discussed at handovers, in weekly MDTs and morning meetings.
- Staff identified and responded to any changes in risks to, or posed by, patients. We saw that they changed patient observation levels in line with changes in risk.
- Staff followed procedures to minimise risks where they could not easily observe patients. For example having extra staff to complete 1:1 observations, allowing the core clinical staff to be present in communal areas and complete routine observations of the ward.
- Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Information on the procedure and frequency of searches was available to patients in their welcome booklets.

Use of restrictive interventions

- Levels of restrictive interventions were reducing. Staff had recorded 17 incidents of restraint in the three months before this inspection. Between 1 March 2019and 31 July 2019 the service reported 47 incidents of restraint for 13 patients. In this period (1 March 2019-31July 2019), staff reported five incidents of prone restraint and one rapid tranquilisation. There were eight incidents of seclusion in this period.
- Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.
- Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. De-escalation was taught during the prevention management of violence and aggression training, which at the time of this inspection 88% of staff had up to date training in.
- Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff we spoke with were knowledgeable about the principles of the Mental Capacity Act.
- Staff did not always clearly document physical health observations post rapid tranquilisation in line with national guidance. We saw in seven records staff did not record blood pressure, pulse, or temperature of patients

post rapid tranquilisation and did not always record patients breathing rate. This is important because rapid tranquilisation medicine can cause serious medical side effects and over sedation.
- When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines.
- Staff followed best practice, including guidance in the Mental Capacity Act Code of Practice, if a patient was put in long-term segregation.

Seclusion room

- On Acorn ward there was one seclusion room. However, in the last six months there had been three occasions where the seclusion facility was in use and so a patient had been secluded in their bedroom. The hospital was developing an additional seclusion room although the date for this work to be completed was not yet known. Staff appropriately recognised that seclusion was being used and monitored and reported this appropriately. However, they also expressed concerns about the safety for patients being secluded in their bedrooms.

Safeguarding

- Staff received training on how to recognise and report abuse, appropriate for their role.
- Staff kept up-to-date with their safeguarding training, at the time of this inspection 78% had up to date training and the rest were booked into receive the training. Where staff were due to complete training, they were booked onto courses.
- Staff could access advice from their manager and other senior leaders in the hospital. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.
- Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff reported good relationships with the local safeguarding authority. The hospital had a safeguarding lead that staff could go to for advice.
- Staff followed clear procedures to keep children visiting the ward safe. They had access to private visiting rooms so that children did not have to enter the ward.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns.
- A safeguarding referral is a request from a member of the public or a professional to the local authority or the

police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

- Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Staff access to essential information

- Patient notes were comprehensive and all staff could access them easily. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. The service was transitioning to fully electronic records. Agency staff were able to access records they needed to provide care.
- When patients transferred to a new team, there were no delays in staff accessing their records.
- Records were stored securely.

Medicines management

- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. However, we saw one patient specific medicine that did not have a dispensing label on it that should have done. We raised this at the time of inspection and the provider took steps to ensure medicines were appropriately labelled.
- The hospital had a pharmacist that completed audits of medicines administration and raised errors with the management team. We reviewed 41 out of 83 medicines errors reported in the last year and saw that only 3 had occurred on Acorn ward.
- Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.
- Staff stored and managed medicines and prescribing documents in line with the provider's policy.
- Staff followed current national practice to check patients had the correct medicines.
- The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

- Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Track record on safety

- The service had a good track record on safety.
- The service reported three serious incidents between August 2018 and July 2019. These three incidents involved one incident of violence meeting serious incident criteria, one accident meeting serious incident criteria and one allegation of abuse (theft of a bankcard). We saw that staff had investigated and learned from these incidents. There had been no serious incidents in the six months before this inspection.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents to report and how to report them.
- Staff raised concerns and reported incidents and near misses in line with provider policy.
- Staff reported serious incidents clearly and in line with the provider's policy.
- The service had no never events on the ward.
- Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. The provider had a policy that staff could access.
- Managers debriefed and supported staff after any serious incident. Staff had access to the hospital psychologist to debrief after incidents.
- Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.
- Staff received feedback from investigation of incidents, both internal and external to the service. This learning was discussed in supervision (if appropriate) and in team meetings, as well as through email bulletins.
- Staff met to discuss the feedback and look at improvements to patient care. They did this through team meetings monthly, as well as senior managers attending governance meetings regularly in the hospital, and with other similar services owned by Cygnet.
- There was evidence that changes had been made as a result of feedback. For example, staff had responded to incidents of assault on staff by increasing the number of

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

Good ●

staff on shift and by giving patients more activities as well as by not locking doors that did not need to be locked to allow patients more freedom of movement in the ward.

- Managers shared learning with their staff about never events that happened elsewhere.

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.
- Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We saw this was the case in the three care records we reviewed. However, we did not always see clear documentation of clients wishes.
- Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. A local GP attended the ward weekly and there was a practice nurse on site to meet patients' physical health needs. Staff facilitated patients accessing specialist health teams.
- Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. This included positive behavioural support plans, and plans to manage risk we saw this in the care records were viewed.
- Staff regularly reviewed and updated care plans when patients' needs changed. They did this as required, as well as having regular multidisciplinary ward round meetings, and one to ones with patients' named nurse.
- Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff provided a range of care and treatment suitable for the patients in the service. This included providing access to psychoeducational groups, individual talking therapy and meaningful activities in a timetable. These included daily living skills, and patient directed activities. Most organised activities were held Monday to Friday, with the weekend's activities being less structured and run by the nursing staff on shift.
- Staff delivered care in line with best practice and national guidance from the National Institute for Health and Clinical Excellence. This included access to cognitive behavioural therapy in line with NICE guidance and access to psychoeducational groups about psychosis.
- Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. The hospital had its own catering team and provided patients with a range of meal options to meet their needs.
- Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. This included having a gym instructor to help encourage patients to exercise in the hospital's gym, and access to nicotine replacement treatments.
- Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. They used the Health of the Nation Outcome Scale, Medical Early Warning Signs scale and the Global Assessment of Functioning Scale at admission and discharge.
- Staff used technology to support patients. This included a tablet computer to play music, and access to a computer room on site.
- Staff took part in clinical audits, benchmarking and quality improvement initiatives.

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

Good ●

Skilled staff to deliver care

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- The service had or had access to a full range of specialists to meet the needs of the patients on the ward. This included Occupational Therapists and assistants, Social Worker, Psychiatrists, Registered Mental Health Nurses, Psychologists, a Wellness &fitness instructor, a Practice Nurse. Patients also had access to a GP, and a Pharmacist via service level agreements with other local healthcare providers.
- Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.
- Managers gave each new member of staff a full induction to the service before they started work. Contracted agency staff received the same induction as permanent members of staff, which included three shadowing shifts.
- Managers supported staff through regular, constructive appraisals of their work. All staff had up to date appraisals at the time of this inspection.
- Managers supported medical and non-medical staff through regular, constructive clinical supervision of their work. At the time of this inspection all staff had received supervision in line with the provider's policy.
- Staff participated in regular team meetings and managers ensured that information was available for people who could not attend.
- Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.
- Managers made sure staff received any specialist training for their role. Staff training needs were identified in their yearly appraisals and in monthly supervision.
- Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff held regular multidisciplinary meetings to discuss patients and improve their care. These were held weekly, with conference calling facilities to help include care teams from patient's home counties.
- Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.
- Ward teams had effective working relationships with other teams in the organisation. Staff reported good links throughout the hospital, as well as the ward manager having meetings with managers from different hospitals to share learning.
- Ward teams had effective working relationships with external teams and organisations. Staff said that the local community was understanding and supportive of patients when they were on leave. They reported good working relationships with the local authority, and the local GP practice.

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

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- All patients were detained under the Mental Health Act.
- Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The provider reported that 93% of staff had received training on the Mental Health Act at the hospital as of July 2019.
- Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.
- The service had clear, accessible, relevant an dup-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

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

Good ●

- Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.
- Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.
- Staff made sure patients could take section 17 leave(permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.
- Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.
- Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.
- Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

- Staff supported patients to make decisions on their care for themselves proportionate to their competence. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.
- Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of the five principles. The provider reported that 93% of staff had received training on the Mental Capacity Act and Deprivation of Liberty Safeguards at the hospital as of July 2019.
- There were no deprivations of liberty safeguards applications made in the last 12 months. All patients at Acorn ward were detained under the Mental Health Act. There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.
- Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.
- Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

- Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.
- When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.
- The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

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

Good ●

Kindness, privacy, dignity, respect, compassion and support

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff were discreet, respectful, and responsive when caring for patients. We observed this through seeing staff interact with patients on the ward.
- Staff gave patients help, emotional support and advice when they needed it.
- Staff supported patients to understand and manage their own care, treatment or condition.
- Staff directed patients to other services and supported them to access those services if they needed help.
- Patients said staff treated them well and behaved kindly.
- Staff understood and respected the individual needs of each patient.
- Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.
- Staff followed policy to keep patient information confidential.

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

Good ●

Involvement in care

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

Involvement of patients

- Staff introduced patients to the ward and the services as part of their admission.
- Staff involved patients and gave them access to their care planning and risk assessments.
- Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).
- Staff involved patients in decisions about the service, when appropriate, including recruiting new staff.
- Patients could give feedback on the service and their treatment and staff supported them to do this.
- Staff supported patients to make advanced decisions on their care. Staff made sure patients could access advocacy services.

Involvement of families and carers

- Staff informed and involved families and carers appropriately.
- Staff supported, informed and involved families or carers. They had held two carers events and were due to have another shortly after this inspection where patients at the hospital were putting on a pantomime.
- Staff helped families to give feedback on the service.
- Staff gave carers information on how to find the carer's assessment.

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 Bed management

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The provider reported that the annual average bed occupancy rate was 91% for Acorn Ward as of July 2019.At the time of this inspection nine of the ten bedrooms were in use by patients.
- Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. There had been issues in finding a placement for a couple of patients which had increased the average length of stay to 309 days as reported in July 2019.However, at the time of this inspection the average length of stay had reduced to 33 days.
- The service took patients from across England.
- Managers and staff worked to make sure they did not discharge patients before they were ready.
- When patients went on leave there was always a bed available when they returned.
- Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient.
- Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

- The service had reducing numbers of delayed discharges in the past year. There were three patients whose discharge had been delayed due to a lack of alternative placements.
- Managers monitored the number of delayed discharges.
- Staff told us the only reasons for delaying discharge from the service were clinical.
- Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.
- Staff supported patients when they were referred or transferred between services.
- The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. All patients could keep their personal belongings safe. On the ward there were quiet areas for privacy.

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

Good ●

- Each patient had their own bedroom, which they could personalise. We saw that patients had brought in their own rugs and decorations.
- Patients had a secure place to store personal possessions. They could not lock their rooms, but could store valuables in the ward safe.
- Staff used a full range of rooms and equipment to support treatment and care. Patients could access the internet through the hospitals computer café.
- The service had quiet areas and a room where patients could meet with visitors in private.
- Patients could make phone calls in private. We identified that the phone room had no source of light inside and would be dimly lit through the window to the main ward area if patients wanted to use it with the door closed. Staff arranged for a contractor to come the week after this inspection to install appropriate lighting. Patients could use their own phones as long as they did not have a camera. The ward had some phones that did not have a camera that patients could transfer their SIM cards to in order for them to use.
- The service had an outside space that patients could access easily. Patients could make their own hot drinks and snacks and were not dependent on staff. The service offered a variety of good quality food.

Patients' engagement with the wider community

- Patients had access to opportunities for education and work, and supported patients.
- Staff helped patients to stay in contact with families and carers.

Meeting the needs of all people who use the service

- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The wards met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service could support and make adjustments for disabled people and those with communication needs or other specific needs.
- Patients could access information on treatment, local service, their rights and how to complain.
- The service had information leaflets available in languages spoken by the patients and local community.

- Managers made sure staff and patients could get help from interpreters or signers when needed.
- The service provided a variety of food to meet the dietary and cultural needs of individual patients.
- Patients had access to spiritual, religious and cultural support. The hospital had a chaplaincy service and would liaise with local religious leaders.

Listening to and learning from concerns and complaints

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.
- Between August 2018 and July 2019, the service reported 18 complaints from patients at Acorn Ward. Eleven of these were not upheld, two of these were upheld and five were under investigation. None had been referred to the ombudsman. The service reported 21 compliments in the same time period.
- Patients, relatives and carers knew how to complain or raise concerns.
- The service clearly displayed information about how to raise a concern in patient areas. Patients also had access to complaints information in their welcome packs, and routes to raise concerns individually, as well as in community meetings.
- Staff understood the policy on complaints and knew how to handle them.
- Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.
- Managers investigated complaints and identified themes.
- Staff protected patients who raised concerns or complaints from discrimination and harassment.
- Patients received feedback from managers after the investigation into their complaint.
- Managers shared feedback from complaints with staff and learning was used to improve the service.
- The service used compliments to learn, celebrate success and improve the quality of care.

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

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

Good ●

Good ●

Leadership

- Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. They were visible in the service and supported staff to develop their skills and take on more senior roles.
- The ward manager had been in post for six months at the time of this inspection. Staff reported good working relationships within the hospital's senior leadership team.

Vision and Strategy

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- The service vision was outlined in the standard operating procedure for the service. The manager was involved in service development but had only been in post for six months. They met with similar services provided by Cygnet to discuss how to improve performance.
- Staff were aware of the provider's corporate values and felt that they helped provide patient centred care.

Culture

- Staff felt respected, supported and valued. They felt the service promoted equality and diversity, and provided opportunities for career development. They could raise concerns without fear.
- Staff felt the culture on the ward was positive, and that they enjoyed working there. They had recently had an away day to focus on team building.
- Staff knew the whistleblowing process and how to raise concerns. Staff felt able to raise concerns without fear of victimisation.

Governance

- Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- The manager had regular updates on their ward's performance against key performance indicators, for example training rates and incidents. These were displayed on dashboards that were updated monthly. There were systems in place to ensure that where performance issues were identified (for example where staff needed to complete training) these were addressed. Staff audited infection control compliance and displayed reminders to help improve performance.

Management of risk, issues and performance

- Ward teams had access to the information they needed o provide safe and effective care and used that information to good effect.
- Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.
- The hospital had a main risk register, and an overlapping local action plan. This allowed them to track ongoing organisational risks, as well as managing short term risks effectively.
- Staff felt that financial pressures did not effect clinical care and felt this was evidenced by the policy of overrecruiting healthcare support workers to ensure that any enhanced observations were conducted by extra staff outside the set safer staffing numbers.

Information Management

- The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.
- Staff had good access to information systems, including a dedicated training laptop and computers to update their clinical notes.

Engagement

- The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.
- The ward had only been open for a year and half, but reported good links with local organisations as well as

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

Good 🟢

regular carer events. Staff felt that they could impact on service development and we saw that they took feedback from patients and carers seriously and displayed this on a 'you said, we did' board in the ward.

Learning, continuous improvement and innovation

- Learning was shared between other psychiatric intensive care services run by the same provider through regular meetings.

- The service was not accredited under the Accreditation for Inpatient Mental Health Services for Psychiatric Intensive Care Units or registered with the National Association of Psychiatric Intensive Care Services.

Forensic inpatient or secure wards

Good 🟢

Safe	**Requires improvement** 🟠
Effective	**Good** 🟢
Caring	**Good** 🟢
Responsive	**Good** 🟢
Well-led	**Good** 🟢

Information about the service

Cygnet Hospital Woking provides low secure services for men and women. At the time of inspection, there were two wards in use.Greenacre ward 18 beds for men, low secure admission, assessment and treatment Oaktree 11 beds for women, low secure admission, assessment and treatment

Are forensic inpatient or secure wards safe?

Requires improvement 🟠

Safe and clean environment

- The wards were single sex and complied with guidance on single sex accommodation.
- Both wards were clean. Both staff teams had their own dedicated cleaning team with a housekeeping manager who completed regular cleaning audits to ensure the premises were clean and hygienic. The housekeepers monitored the cleaning schedule to ensure all work had been completed. The patients were expected to tidy their own bedrooms for the cleaners to clean.
- The layout of the wards included some blind spots which staff were aware of and these were mitigated through observations. A member of staff was allocated to complete observations of communal areas for each shift.
- Staff members completed yearly environmental risk assessments to ensure the wards were safe. Electrical equipment had up to date PAT testing. The maintenance systems did not always identify and repair

issues. For example, on the day of inspection, we found we could lock the door of the de-escalation room from the inside. We brought this to the managers attention and it was repaired immediately.

- Staff in both wards had access to appropriate alarms and nurse call systems. In Oaktree ward staff were not clear about what to do if a fob (electronic locking system) system failed or the unit needed to be locked using another system. The senior managers ensured that the policy was reviewed at the inspection.

Safety of the ward layout

- In both wards there was an up to date environmental risk assessment which included an assessment of ligature risks (a ligature point is anything that can be used to attach a cord, rope or other material for hanging or strangulation) and mitigating actions for staff. For example, in Greenacre ward the bathroom doors did not have ligature free hinges but these were identified and mitigation through enhanced staff observation of high-risk patients. Bedroom doors were of an anti-barricade type and had two-way observation panels in. In both wards a ligature assessment was completed. All ligature points had mitigating actions in place to protect the patients.

Maintenance, cleanliness and infection control

- All ward areas were hygienic, had good furnishings and were well-maintained. Forensic inpatient or secure wards.
- In both wards, staff followed the providers policies on infection control. For example, there were handwashing guidance in all toilets to ensure staff cleaned their hands appropriately.

Forensic inpatient or secure wards

Clinic room and equipment

- The clinic rooms on both wards were clean, fully equipped, and were seen to have accessible resuscitation equipment. We checked the resuscitation equipment and found it was well maintained and complete. Medicines were stored securely. Doors were locked to clinic rooms with access restricted to appropriate staff.
- There was provision to store Controlled drugs (CD)securely. Staff monitored and recorded room and refrigerator temperatures daily. These were within the required range.
- Unwanted medicines were recorded and disposed of appropriately. Regular checks of emergency medicines and equipment were carried out by staff and recorded. All medical equipment and medicines checked on the day of inspection were in date including oxygen.
- The clinics contained appropriate equipment including a blood pressure monitor, scales and hand washing basin.

Safe staffing

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Both wards had enough nursing staff to keep patients safe. The service had developed a staffing matrix that identified the minimum staffing levels for the ward based on the number and complexity of patients on the ward. The managers told us they used the matrix to plan the core rota and would increase staffing levels based on individual patient need and level of observations.
- In both wards the establishment levels were met in relation to support workers and they were nearly met in relation to nursing staff. In Oaktree ward there were two nurse vacancies and in Greenacre ward one. All vacancies were advertised with interviews happening shortly.
- Both wards used regular well-known bank staff. In Oaktree ward in the last year they reduced use of agency staff significantly following staff recruitment. For example, in the three-month period May to July 2019,269 shifts were covered by agency staff and in the three-month period September to November 2019 only110 hours were covered by agency staff (each shift being11 hours.) The use of bank staff remained the same with93 shifts filled by bank staff, in the

three-month period May to July 2019.•In the three-month period September to November2019 in Greenacre ward, shifts were covered by 110agency nurses,240 shifts by agency support staff and approximately 100 shifts filled by bank staff. The managers said they could alter staffing levels according to the needs of the patients.
- On both wards staff said the level of staffing was proactive rather than reactive. This meant that managers had anticipated when they needed extra staff and had sufficient staff on duty to meet the needs of the patients.
- Staff completed an incident form if either a bank or agency staff member could not cover a shift, but both managers stated it was rare.

Nursing Assistants

- As previously stated, the vacancy rate across all staff in the two wards was low. In Oaktree ward there were two nurse vacancies and interviews were taking place shortly. In Greenacre ward there was a nurse vacancy. Both wards had a full complement of support staff. Sickness levels were currently low, on average 2%across the two wards although it fluctuated from month to month.
- There was adequate medical cover day and night. Each of the wards had a consultant, and a specialist doctor to support them. A doctor could attend the wards in an emergency. If they were busy with another emergency and could not attend quickly, emergency services would be contacted.

Mandatory training

- Overall staff members across all the teams were up to date with their mandatory training. This training included areas of learning essential for safe practice such as safeguarding children and medicines management.
- In both wards, on average 95% of mandatory training had been completed by staff members across the teams. This met the providers target of 95% for completion of mandatory and statutory training.

Assessing and managing risk to patients and staff

- In all care files reviewed we found staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and

managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in a restrictive intervention's reduction programme.

Assessment of patient risk

- In both wards there was evidence that, following incidents, risks were discussed within the multidisciplinary ward round/ business meetings. Risk assessments were then reviewed and updated. Incident records demonstrated that staff used restraint and seclusion only after attempts at de-escalation had failed.

- There was a daily multidisciplinary ward handover where staff reviewed patients' presentation over the previous 24 hours. There were risk meetings with senior members of the multidisciplinary team which enabled managers and to be aware of any incidents, risks and safeguarding concerns and to provide support to ward staff where necessary.

- Staff we spoke with were aware of individual patients' risks and care plans were in place to prevent or reduce risks. Psychology staff worked with patients to develop an individual formulation which included an individual positive behaviour support plan identifying individual triggers, distraction and de-escalation techniques.

- Staff members used the Dundrum tool kit to assess patients risk levels. Some of the patients were Ministry of Justice patients on section 41 and the service needed to be able to provide assurance that the patients can be downgraded to a low secure environment and can monitor the risks in real-time. Some patients maybe serving life sentences and the Dundrum tool kit is the assessment tool used to assess the risks to other patients and to the community.

- Where patients presented with an increased risk, staff managed these using observations in line with the hospital's observation and engagement policy. On both wards we saw staff positively engaging with patients who were subject to increased observation levels.

Management of patient risk

- Staff were aware of and dealt with any specific risk issues, such as incidents of self harm. Staff identified and responded to changing risks to or posed by patients. The managers stated that the staff team were mindful that an increase in incidents could indicate a change in a patient's mental health.

- Staff followed good policies and procedures for use of observation, including to minimise risk from potential ligature points, and for searching patients' bedrooms. In both wards there was a list of banned articles. These included items like alcohol or nail polish. The list was on the front wall. There were also restricted items which could only be used on request such as lighters. Staff members supervised their use.

- Staff adhered to best practice in implementing a smoke-free policy. All sites were smoke-free.

- The wards were able to notify informal patients of their rights and had information leaflets detailing their rights.

Use of restrictive interventions

- Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. At the time of the inspection 90% of the staff team had received de-escalation training and the remaining staff were new starters who were scheduled to attend this training. Staff members explained how the training put a focus on having a calm peaceful environment.

- Staff told us they made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

- In both wards there were no prone (face down)restraints. In Oak ward there were incidences of oral rapid tranquilisation.

- In Greenacre ward there were 20 restraints between December 2018 and December 2019. However, the majority involved one patient with challenging behaviour.

Seclusion

Seclusion room

- On Oaktree ward there was one seclusion room. Greenacre did not have a seclusion room, but did have a de-escalation room. However, in the last month there had been an occasion where the seclusion facility was in use and so a patient had been secluded in their bedroom. The hospital was developing an additional seclusion room although the date for this work to be completed was not yet known. Staff appropriately

Forensic inpatient or secure wards

recognised that seclusion was being used and monitored and reported this appropriately. However, they also expressed concerns about the safety for patients being secluded in their bedrooms.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. The teams had an adult safeguarding lead. The majority of staff had safeguarding training. The training was a mandatory course.
- A member of the senior team was the safeguarding team lead. They monitored all safeguarding referrals and staff could access if they had any safeguarding concerns.
- The staff teams were experienced in working with patients who were known to Social Services.
- The staff teams worked closely with local safeguarding services. They followed local safeguarding board procedures and appropriate national guidance.
- Staff members spoken with were confident about making a safeguarding referral and were able to give examples when they had done so.

Staff access to essential information

- Staff had access to clinical information and it was easy for them to maintain high quality clinical records.
- Patients' records were held both on a secure electronic recording system which could be accessed by all staff employed by the service and in paper records. Agency staff working on a longer-term contract could also be provided with an account to log on to the system. Agency staff working for shorter periods were made aware of patients' needs through their ward induction and the staff handover. Key information was also recorded on observation and allocation records.

Medicines management

- The service did not use systems and processes to safely administer and store medicines. In Oaktree ward inhalers which were prescribed and administered to patients were not labelled and stored on the same shelf of a medicine cabinet. In the post rapid tranquilisation

records we reviewed, for the two weeks prior to inspection, only breathing observations had been recorded by staff. Other required physical observations had not been recorded.

- On Greenacre ward they did not have had effective policies, procedures and training related to medication and medicines management which were known to staff. Over the last year the pharmacist had identified over one hundred medication errors but there was no clear system to ensure the errors once identified would not be repeated. On Greenacre ward they had not updated the induction checklist for agency staff who administered medication for a year despite information that many of the medical administration errors were by agency staff members.
- Staff members were able to describe the observation levels, policies and procedures they followed if rapid tranquillisation was used. However, in the post rapid tranquilisation records we reviewed, for the two weeks prior to inspection, only breathing observations had been recorded by staff. Other required physical observations had not been recorded.
- Staff reviewed the effects of routinely prescribed medicines on patients' physical health regularly and inline with National Institute for Health and Care Excellence (NICE) guidance. Medicines reconciliation on admission and prescribing was completed by specialist doctors who supported consultants. They ensured patients' medications levels were not excessive and not used to control patients' behaviour. In both wards monitoring for patients prescribed antipsychotic medication and effects on their physical health was completed by the specialist doctors. Both wards had pharmacy input who monitored medication weekly.

Track record on safety

- Both the senior management team and the ward managers managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and there was some evidence of shared lessons learned with the whole team and the wider service. However, this was mixed. For example, in Greenacre ward one incident involved patient confidentiality and we saw minutes of the ward business meeting to show how this incident had been shared with the whole team. However, incidents about medication errors showed limited learning in the staff team.

Forensic inpatient or secure wards

Good ●

- When things went wrong, staff apologised and gave patients honest information and suitable support.

Reporting incidents and learning from when things go wrong

- Staff recognised incidents and reported them appropriately to senior managers in the organisation. Staff and managers understood their responsibilities under the duty of candour, the incident reporting system prompted staff to identify issues which met the criteria and staff gave patients and families a full explanation if things went wrong.
- Managers mostly debriefed and supported staff after any serious incident. Staff could also attend reflective practice sessions facilitated by the psychologist where they could reflect on incidents. However, staff in Greenacre ward stated they did not receive support after a violent incident three weeks ago and were left shaken and unclear about how they and the patients were safe from further incidents. There were a further three violent incidents the following day.
- In Oaktree ward there were on average 20 incidents a month. The highest number was in June with 160incidents, but these involved a small number of patients. Over the last six months incidents have reduced with, for example 22, in October 2019.
- In Greenacre ward there were 333 incident last year. 96medication errors had been highlighted by the Pharmacist during their monitoring.
- Staff members did not always learn from incidents involving medication errors. For example, in Greenacre ward the high number of medication errors by agency staff did not result in any changes to the induction checklist. However, an incident about patient confidentiality resulted in changes to the way information was managed and was discussed at both team and ward business meetings.

Are forensic inpatient or secure wards effective?
(for example, treatment is effective)

Good ●

Assessment of needs and planning of care

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed.Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff developed care plans for each patient. We looked at 12 care records across both wards. Care plans were person centred, individual, personalised, holistic and recovery orientated. They reflected the needs of each patient and included a risk management care plan, a behavioural support plan, a physical health care plan including ongoing monitoring of patients' physical health.
- In both wards care plans were very detailed and reflected the patients' views of their needs as well as those of professionals. Patients were able to update their plans regularly.
- Care plans included a section which defined how a patient wished to be referred to in the care plan. Plans included detailed examples of trigger that may upset patient and advised staff how best to support each patient if they became distressed.
- All patients had their physical health assessed soon after admission and reviewed during their time on the ward.
- Psychology and occupational therapy staff completed assessments following a patient's admission to the ward and developed individual plans based on patient needs. Patients received an individual psychological formulation which identified the group and individual therapeutic approaches which would be beneficial to the patients. The plans also incorporated a positive behaviour support plan detailing individual trigger points and appropriate distraction and de-escalation techniques.

Forensic inpatient or secure wards

Best practice in treatment and care

- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff members provided care and treatment based on national guidance and evidence of its effectiveness. There were care pathways in place that showed current National Institute for Health and Care Excellence (NICE)guidance for staff to follow. Evidence seen in the care files confirmed that the service followed NICE guidance when prescribing medication and in relation to psychosis, schizophrenia and depression in patients. Individual and group therapies were available led by psychologists. Therapies offered included a cognitive behavioural therapy and exercise and mindfulness programme. A health and wellbeing worker provided relaxation therapy for patients.
- Patients could access a range of therapeutic activities to develop their recovery, daily living skills and support independence. These included art and crafts, relaxation, walks, mindfulness, pool and gym exercise programmes.
- The staff teams monitored the effectiveness of care and treatment and used findings to improve them. The service ensured analysis of outcome measures to inform service development. Staff used outcome measures like Health of the Nation Outcome Scales where patients answered a series of questions about their health and wellbeing before and after treatment to determine the effectiveness of their treatment. Clinicians like occupational therapists also used own specialist outcome measures. Staff spoken with felt it was a useful measure of how patients had benefitted from the care and treatment they received.
- Staff participated in clinical audit, benchmarking and quality improvement initiatives. For example, they completed care plan and risk assessment audits.

Skilled staff to deliver care

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- The service had or had access to a full range of specialists to meet the needs of the patients on the ward. This included Occupational Therapists and assistants, Social Worker, Psychiatrists, Registered Mental Health Nurses, Psychologists, a Wellness &fitness instructor, a Practice Nurse. Patients also had access to a GP, and a Pharmacist via service level agreements with other local healthcare providers.

Appraisals

- At the time of inspection supervision rates across the service were in the region of 98% overall. Managers provided staff with regular clinical and managerial supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development). Staff spoken with were satisfied with the quality and frequency of supervision.
- Managers ensured staff members had annual appraisals of their work performance and had access to regular team meetings.
- Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge.
- Managers ensured that staff received the necessary specialist training for their roles. Managers were supportive of staff accessing additional training where this was relevant to their role. Managers also arranged bespoke training for staff to assist them with their role.
- Managers, with assistance from the human resources team dealt with poor staff performance. Any issues of concern were generally followed up in supervision following the providers staff performance policy.

Multi-disciplinary and inter-agency team work

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care.
- The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- There was a daily multi-disciplinary handover where the multi-disciplinary team received information about

Forensic inpatient or secure wards

patients on the ward. We saw examples of where referrals had been made to members of thematic-disciplinary team which had been acted on promptly.

Adherence to the MHA and the MHA Code of Practice

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them. Staff knew who the Mental Health Act administrator was and could access support and advice on implementing the Mental Health Act and its Code of Practice if required.
- We reviewed seven patients' records all of which demonstrated they had their rights under the Mental Health Act explained to them on admission and at regular periods through their detention.

Good practice in applying the MCA

- Staff supported patients to make decisions on their care for themselves proportionate to their competence. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.
- There was a separate Mental Capacity Act (MCA)mandatory training course. Consent to treatment and capacity requirements were completed in most files reviewed.
- Overall staff generally demonstrated a good understanding of the Act.
- Managers made sure that staff could explain patient's rights to them. The wards had a policy on the Mental Capacity Act and Deprivation of Liberty Safeguards(DoLS) which staff were aware of and could refer to.
- Staff were competent in assessing capacity. When we spoke to them, staff were clear on what actions they would take if a client's capacity was fluctuating.
- Decisions regarding capacity or competence were documented in patients' care records and discussed at every multidisciplinary meeting on the wards. Staff members attended best interest meetings.
- We saw evidence of the use of consent forms, which were all completed and signed.

Are forensic inpatient or secure wards caring?

Good ●

Kindness, privacy, dignity, respect, compassion and support

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- All the interactions we saw between the staff members and the patients were kind, respectful and showed an understanding of the patient's needs.
- Patients were mostly positive about the way staff treated them. In both wards' patients had mixed feedback. Some patients felt the staff did not ensure they were safe. Some patients in Greenacre ward felt the staff did not ensure they were safe. Some patients in Greenacre ward said that did not always feel safe and recently tried to make themselves safe by keeping to their rooms or leaving rooms when potentially violent patients came in. The provider told us they were reviewing the pathways for patients who required a period of seclusion to address patient safety across the ward. The majority of patients we spoke with said staff were supportive and caring.
- The teams respected patient's confidentiality; they used lockable bags to carry any information outside the service.

Involvement in care

- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff members involved patients and those close to them in decisions about their care and treatment. decisions about their care. Patients were always invited to attend their care programme approach (CPA) reviews and ward rounds but sometimes chose not to attend or were not well enough to attend. Parents and carers were also invited to CPA reviews.

Forensic inpatient or secure wards

Good ●

- All patients spoken with told us staff members described treatment options and gave them choices. For example, in both wards the patients requested food changes. This was implemented by the staff teams.

Involvement of patients

- The service held regular community meetings to provide patients with an opportunity to give feedback on service delivery and discuss potential changes to the service. In Oaktree ward patients had requested to have animals on the ward and the staff team supported them to keep rabbits as pets. In Greenacre ward patients requested a change from movie night and staff members started a curry evening. They requested their own walking group rather than join another voluntary organisation group.
- Patients had access to advocacy services.
- A manager stated patients used to be involved with the recruitment of staff in all teams but had not done so recently. In Oaktree ward a patient had been on the interview panel for the occupational therapist nine months ago.
- Staff encouraged patients to attend their review meetings and staff met with some patients to design a care plan together. Most patients we spoke with said they attended reviews and had copies of their care plan. Those that did not have a copy stated that they had discussed their care plan with staff members.
- Patients were encouraged to give feedback and there were several suggestion boxes around the ward where they could place requests and suggestions.

Involvement of families and carers

- Staff members involved families in the care of the patient as appropriate. Most family members we spoke with said staff involved them in the care and treatment of their relative. There were carers event like a BBQ four times a year. Carers told us that helps keep them informed of any developments within the service.
- In Greenacre ward the doctor visited the ward at weekends to meet relatives when they visited. Relatives told us they felt highly supported during patients' leave and always had someone they could call if they were struggling.
- Relatives told us they felt very involved in communication about their relative's progress.

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

Good ●

Access and discharge

- Oaktree ward had one patient on long term segregation for their safety and the safety of other patients and Greenacre had recently terminated long term segregation for another patient but were maintaining a programme of reintegration. Both staff teams tried a series of reintegration of these patient into the wards. The teams and senior management in the organisation had worked closely with commissioners and external organisations to organise a bespoke package of care for patients to be rehoused in the community.
- In both wards referral to assessment times was two days. On average patients waited twenty days for initial assessment to the start of treatment.
- The data provided to us prior to our inspection stated that on average bed occupancy for the last financial year was about 98%. The average length of stay in, for example, Oaktree ward was 18 months. In Greenacre ward there were two delayed discharges last year. The manager told us this was mostly down to finding from the community teams. in Oaktree ward there was one delayed discharge in the last year. The manager told us this was because of lack of staff in the community teams.
- There was always a bed available when patients returned from leave. When patients were moved or discharged, this happened at an appropriate time of day.
- Staff planned for patients' discharge, including good liaison with care coordinators and family where appropriate. This process started from the point of admission.
- Staff supported patients during referrals and transfers between services, for example, if they required treatment in an acute hospital or transfer to a psychiatric intensive care unit.

Forensic inpatient or secure wards

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had access to a range of rooms and facilities to support their recovery in the wards. For example, in Greenacre ward there was a large communal area with a pool table. Patients had access to a well-equipped gym and occupational therapy kitchens for meaningful activities like baking and meal preparation.
- Both wards had lift access. For example, in Greenacre ward the ward was on two floors with a lift to the bedrooms. Both wards had a TV lounge with comfy chairs, a patients' kitchen, offices and meeting rooms.
- Patients could personalise bedrooms. They had somewhere secure to store their possessions. In Oaktree ward patients had access to an additional spare room to store larger items of belongings.
- In both wards there were quiet areas where patients could meet visitors. Children could visit and use a room off each ward in the larger building.
- Patients could make a phone call in private, either using their own mobile phones if permitted or use one of the ward phones.
- Patients had access to outside space. For example, in Oaktree ward they did not have a garden off the ward, but patients were offered visits to the garden every two hours.
- Patients could make hot drinks and snacks, with support if needed. This was individually assessed in line with their treatment programme.

Patients' engagement with the wider community

- When appropriate, staff ensured that patients had access to activities in the community.
- Staff supported patients to maintain contact with their families and carers. Staff encouraged them to develop and maintain relationships, both within the services and the wider community. For example, in Oaktree ward a patient volunteered in a charity shop an another worked in the organisation's kitchen.

Meeting the needs of all people who use the service

- Both wards had made adjustments for patients who required disabled access. For example, both wards had lift access and grab rails were available. In Oaktree ward there was a toilet with an elevated seat to assist patients.

- Staff supported patients to access treatment when their first language was not English. Staff were able to access interpreters for appointments and to translate letters. Interpreters and signers were sourced through the local authority. In Greenacre ward staff accessed an interpreter for a patent who spoke an African language. The interpreter assisted the patient in review meetings and ward rounds.
- On both wards the information leaflets were in English because the wards did not often have patients whose first language was not English. Staff told us that they could request these through the organisation if they were required.
- The food was of a good quality and patients could make hot drinks and snacks at any time. Patients had a choice of food, and the menu could be tailored to meet a range of dietary requirements such as vegan and halal options. Staff ensured that patients had access to appropriate spiritual support. Patients had access to a multi faith room in the building.

Listening to and learning from concerns and complaints

- Greenacre ward received sixteen complaints in the last year. One was upheld. None were referred to the Ombudsman. In Oaktree ward there were 23 complaints with the majority from one patient. Two were upheld. None were referred to the Ombudsman.
- All staff treated concerns and complaints seriously, investigated them and learnt lessons from the results. For example, one complaint in Oaktree ward investigated by the manager was a complaint by a patient that they had restrictions on when they could say prayers at night. As a response the staff agreed they could say prayers at any time. In Greenacre ward a patient complained about access to the multi faith room and staff ensured they had the room booked each Sunday.
- The managers phoned carers and spoke with patients to discuss their concerns. These were addressed with the staff involved. Patients reported they were happy with the outcomes.
- Any formal complaints about the service management were investigated by the senior management team.
- Staff told us they spoke about how to make a complaint at their first meeting with a patient.

Forensic inpatient or secure wards

Good ●

- On both wards there were posters and information leaflets for patients telling them they could complain and how to do so. Most of the patients we spoke with told us they were confident about making a complaint and knew how to do so.
- Patients told us they knew how to complain and were confident that the staff would act upon them.

Are forensic inpatient or secure wards well-led?

Good ●

Leadership

- Leaders had the skills, knowledge and experience to perform their roles. Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Leaders were visible in the service and approachable to patients and staff. Members of the board of directors had visited both wards.
- Leadership development opportunities were available, including opportunities for staff below team manager level. For example, the ward managers were completing a leadership course at the time of our inspection.

Vision and Strategy

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- The managers promoted a positive culture that supported and valued staff. All staff knew and understood the service visions and values and applied them to their work. Staff spoke positively about senior management in the service. Senior managers had visited the wards.
- Staff could explain how they were working to deliver high quality care within the budgets available. All managers completed a benchmarking document (a document that compares their performance with other teams about waiting times, outcomes, discharge).

Culture

- Staff mostly felt respected, supported and valued. However, staff in Greenacre ward felt there was no clear pathway for the use of seclusion. They felt a recent incident had not been handled very well by the provider and had left feeling unsupported.
- Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staff were committed, hardworking and mutually supportive of each other. Staff spoke positively about their team colleagues and were proud of the work they did.
- Staff morale was high across the service and staff turnover was low. Staff members told us that despite the recent incidents staff morale was high as they worked well as a team.
- Sickness and absence rates were low across both wards overall.
- All staff we spoke with knew how to use the whistle-blowing process. Staff told us that they felt able to raise with the provider with any concerns they might have about patient care or treatment.

Governance

- The governance systems were sufficient to ensure the safe care and treatment of the patients.
- The provider had introduced systems to check the team's performance and make changes when necessary. Staff had implemented recommendations from reviews of complaints, and safeguarding alerts. They undertook or participated in audits like care plan audits and acted on the results when needed. They understood arrangements for working with other teams, both within the service and externally, to meet the needs of the patients.
- Senior managers had systems to ensure that staff complied with mandatory training and attended clinical supervision and annual appraisals. They monitored complaints and incidents across the service and these were investigated where appropriate.
- The senior manager of the wards said they had enough time and autonomy to manage the service effectively. The senior managers had the support of a small team of administrators. Both managers felt they had sufficient support.

Forensic inpatient or secure wards

- Regular team meetings were held allowing staff to discuss concerns, participate in educational or clinical supervision.
- The service had a systematic approach to continually improving the overall quality of its service. Both the managers could access a business performance report on the electronic system. These were shown to us at the inspection and discussed in staff meetings.

Management of risk, issues and performance

- The service had a clear system for identifying risks. The service kept a risk register on the electronic reporting system. The managers could escalate risks to the risk register. Staff spoken with were aware of what risks they had on the risk register and what the service had in place to address these.
- All staff were trained in clinical risk and use of the electronic reporting system. The service had plans for emergencies like adverse weather which was known to all the team.

Information management

- Both wards had a consistent, systematic approach to continually improving the overall quality of its service. The managers could access a business performance report on the electronic system.
- Patients records were confidential and required information system log ins.

- The managers had access to systems to support them in their management role such as staff performance and absence figures.
- Staff made notifications to external bodies when necessary and these were logged and monitored by governance groups.

Engagement

- The staff teams engaged well with patients and their families. Overall patients stated that staff listened to their feedback and made changes. For example, following feedback from community group and complaints they changed patients support workers, the food they provided, and activities offered.
- The service used surveys, community meetings, one to one meeting and the complaints procedure as formats to pick up the patients' experience of the service.

Learning, continuous improvement and innovation

- All staff were committed to continually improving services and had a good understanding of quality improvement methods. Leaders encouraged innovation and participation in research.
- The staff team showed a commitment to continued improvement through using quality improvement methods.
- The low secure services were part of the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services

Long stay or rehabilitation mental health wards for working age adults

Good 🟢

Safe	**Requires improvement** 🟠
Effective	**Good** 🟢
Caring	**Good** 🟢
Responsive	**Good** 🟢
Well-led	**Good** 🟢

Information about the service

Picasso ward is a longer-term, high dependency rehabilitation unit. It is a new service since the last inspection and this is the first time it has been inspected. Picasso offers a mental health rehabilitation service to adult women and has 21 beds. Patients with a mental health diagnosis stay on average for 12 to 18 months and receive long-term support for their recovery, including medical and nursing treatment and support, occupational therapy groups and interventions, psychology, educational and social support.

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

Requires improvement 🟠

Safe and clean environment

Safety of the ward layout

- The ward was on two floors of the building. Access to the ward was by an electronic fob which would give access to other doors in the hospital except the main entrance which was controlled by reception staff. Staff could observe patients in all parts of the wards. All areas were covered by recorded CCTV cameras and lines of sight enhanced with convex security mirrors. There was a separate reception area with its own door entrance and a visitor's room located next to it.
- All bedrooms had ensuite showers and toilets and had reduced ligature risks. One bedroom had been adapted to allow wheelchair access. The ensuite doors did not

have ligature free hinges but these were identified and mitigation was through enhanced observation of high-risk patients. Bedroom doors were of an anti-barricade type and had two-way observation panels in. Some patients had a small safe in their room for personal items.

- Alarms were available throughout the ward in bedrooms, bathrooms and toilets. Staff carried individual alarms for their safety. Staff and patients said that alarms were responded to quickly.
- Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.
- We saw the annual ligature risk ward plan which was in the office. The last ligature audit had been completed in June 2019.•The ward was an all-female ward and patients' rooms were ensuite.
- There was a separate open kitchen area with hot and cold drinks available for patients. Patients on the wards had access to snacks and hot and cold beverages at all times of the day and night.
- Patient had their own bedroom. Patients were able to store their possessions securely in their bedrooms. All patients had access to their bedrooms and communal areas of the ward at any time. However, staff told us that patients did not have their own keys to their bedrooms and had to ask staff to unlock them if necessary. Managers informed us after the inspection that new keys were being cut and would be available to patients following appropriate risk assessments.

Long stay or rehabilitation mental health wards for working age adults

Good 🟢

- Many patients had wider access across the hospital site with the appropriate leave and access in and out of their own ward areas. Outside the ward, patients could access therapy facilities, a recovery college, a hairdresser and a gym.
- The ward had access to enough therapy spaces, a laundry room, clinic area, bathroom, quiet lounge, and a small staff room. Access to the outside space was via the lounge. However, staff reported to us different times of when this area could be used. It was unclear whether this was a blanket rule that applied to all patients or individuals at risk.
- We raised the issue of patients having access to outside space in the evenings with the provider. Managers told that access could be dependent on what decisions a patient had taken, where to use their leave, and considerations with safety on the ward. They told us that exceptions were made for patients who had engagements off the ward later in the evening.

Maintenance, cleanliness and infection control

- Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. We saw cleaning staff wearing gloves while they were removing waste and cleaning the ward during the inspection. Waste was stored in the right bags according to the type of waste. We saw yellow clinical waste bags in the clinic room and sluice rooms for the disposal of clinical waste.
- Staff did not always follow infection control policy, including handwashing. We did not see staff regularly washing their hands or using the antiseptic hand gel that was available in the ward office, although we did see some staff wearing disposable gloves when necessary.
- Staff told us that, on the lower part of the ward that it was not easy for them to wash their hands without needing to locate a key and unlock a room. This meant that there was a potential risk of infection to other people who might touch the door handle or use the same key. There were no hand-washing sinks in the lower floor ward area.

Clinic room and equipment

- Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. An automated external defibrillator and anaphylaxis pack was in place in the hospital to use in an emergency. Staff checked, maintained, and cleaned equipment.
- Medicines were stored securely. Doors were locked to clinic rooms with access restricted to appropriate staff. There was provision to store controlled drugs (CD)securely. Schedule 4 and 5 controlled drugs were also stored in CD cabinet and monitored similarly to CD's. Staff monitored and recorded temperatures for room and medicine refrigerators and these were within the required range.

Safe staffing

Nursing staff

- The service had enough nursing and support staff to keep patients safe. At the inspection, managers told us that the ward had ten staff nurses and 21 Health Care Support Workers in post. Three team leaders had been appointed recently with two in post and one due to start. The ward manager was permanent and was a qualified mental health nurse.
- Between September 2019 and November 2019, of the total working hours available, 47.14%were filled by bank staff to cover sickness, absence or vacancy for qualified nurses. This had reduced from 59% in September to 37% in November. Managers told us that some of this could be explained by the use of long-term agency staff on nights.
- The main reasons for bank and agency usage for the wards/teams were for clinical reasons or to cover nightshifts and the ward employed three contracted agency nurses for this purpose. Managers told us they were in the process of phasing these out and employing permanent staff.
- In the same period, agency staff covered between 13%and 18% of available hours for qualified nurses and0.19% of available hours were unable to be filled by either bank or agency staff.
- Managers limited their use of bank and agency staff and requested staff familiar with the service.
- All bank and agency staff received a full induction fromward staff and understood the service before starting their shift.

Long stay or rehabilitation mental health wards for working age adults

Good 🟢

- The service was experiencing reducing staff turnover rates. Managers told us that staff turnover had stabilised since September 2019. Managers told us many staff had left before September to study or for promotions.
- Managers supported staff who needed time off for ill health.
- Levels of sickness were low and reducing but there was one member of staff on long-term sick leave. The sickness rate for Picasso ward was 2.5% between August2018 and July 2019.
- One member of staff was on maternity leave.
- Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.
- Managers told us, at the time of inspection, for each twelve hour shift, there were two nurses and six healthcare support workers allocated for day and nightshifts During the day, the ward manager was supernumerary and worked from 9am to 5pm. This was reduced if beds were not filled.
- The ward manager could adjust staffing levels according to the needs of the patients.
- Patients had regular one to one session with their named nurse. Patients told us that they could meet with their named nurse when required.
- Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.
- The service had enough staff on each shift to carry out any physical interventions safely.
- Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

- The ward had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Doctors took part in a unit-wide on-call rota.
- The ward had a permanent consultant psychiatrist and a specialist registrar.
- There was no use of medical locums on Picasso ward.

Mandatory training

- The mandatory training programme was comprehensive and met the needs of patients and staff.
- Managers monitored mandatory training and alerted staff when they needed to update their training.
- Staff on Picasso ward had completed and kept up-to-date with their mandatory training.

- Mandatory training included prevention and managing violence and aggression (PMVA), basic life support, safeguarding and infection control.
- The compliance for mandatory and statutory training courses at date was high. Of the mandatory training courses run by the organisation, staff on Picasso ward had achieved above 86.7%except for responding to emergencies e-learning which was at 80%.

Assessing and managing risk to patients and staff

Assessment of patient risk

- Staff completed risk assessments for each patient on admission. We reviewed 11 risk assessments and found that they were comprehensive, regularly reviewed and reflected the patient's views. Staff used a recognised risk assessment tool called the Short-Term Assessment of Risk and Treatability (START) to help them to assess and make clinical judgements about risk. This was reviewed in multidisciplinary team meetings for each patient.

Management of patient risk

- Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff discussed risks during handovers and multidisciplinary team meetings. They carried out a daily risk assessment for each patient that was discussed at handover to identify and respond to any changes in risks to, or posed by, patients. Doctors told us they had a daily flash meeting every morning to discuss any risk issues.
- Staff followed procedures to minimise risks where they could not easily observe patients.
- Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff on Picasso ward carried out random searches as part of this.

Use of restrictive interventions

- Managers told us the organisation is a member of the Restraint Reduction Network and has locally introduced reducing restrictive practice champions on each ward. Through this the hospital was promoting initiatives to reduce all restrictive practices including physical restraint.
- On Picasso ward, staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Levels of restrictive interventions were reducing.

Long stay or rehabilitation mental health wards for working age adults

Good ●

- Information we received before the inspection showed that between March 2019 and July 2019 Picasso Ward had 19 incidences of restraint (nine different service users) and no incidences of seclusion.
- Information we received before the inspection showed that between March 2019 and July 2019 there were six instances of prone restraint on Picasso ward and two had resulted in the use of rapid tranquillisation.
- At the time of the inspection we were informed about one incidence of prone restraint on Picasso ward in October where a patient was briefly restrained to administer an injection.
- Staff understood the Mental Capacity Act definition of restraint and worked within it.
- Staff followed National Institute of Clinical Excellence guidance when using rapid tranquilisation, however we found that physical health monitoring was not being followed in line with the provider's policy.
- There had been no instances of seclusion on Picasso ward over the reporting period before the inspection, prior to August 2019.
- Staff said they had followed the Mental Health Act 1983 Code of Practice as far as possible to monitor and review patients, while they were secluded.
- There had been zero instances of long-term segregation reported on Picasso ward between March 2019 and July 2019, however in the months prior to the inspection three patients had been secluded in their bedrooms for several days.

Seclusion room

- On Picasso ward there was one seclusion room .However, in the last two months there had been four occasions where the seclusion facility was in use and so a patient had been secluded in their bedroom. The hospital was developing an additional seclusion room although the date for this work to be completed was not yet known. Staff appropriately recognised that seclusion was being used and monitored and reported this appropriately. However, staff were concerned about patient safety and sought support to ensure this arrangement had been considered.

Safeguarding

- Staff received training on how to recognise and report abuse, appropriate for their role.
- Staff told us that their induction had been extensive and helpful for them in carrying out their role.

- Staff kept up-to-date with their safeguarding training. 93 percent of staff on Picasso ward had completed their safeguarding training at the time of the inspection.
- A member of the senior team was the safeguarding team lead. They monitored all safeguarding referrals and staff could access if they had any safeguarding concerns. All staff we spoke to on Picasso ward knew who the named safeguarding lead was and how to contact them.
- Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.
- Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.
- Staff followed clear procedures to keep children visiting the ward safe. We saw a visitor's room that was separated from the main ward area and near to an exit door. This had toys and materials for children available in it.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew how to do this via the online system for the unit. A senior manager was the designated safeguarding lead and staff knew who they were by name.
- A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional. This core service made 56 safeguarding referrals between December 2018 and November 2019.

Staff access to essential information

- Patient notes were comprehensive and all staff could access them easily. Agency staff working on a longer-term contract could also be provided with an account to log on to the system. Staff could gain additional information at handovers.
- The service used a combination of electronic and paper records and staff made sure they were up-to-date and complete.
- Key information was also recorded on observation and allocation records.
- When patients transferred to a new team, there were no delays in staff accessing their records.

Long stay or rehabilitation mental health wards for working age adults

Good 🟢

- Paper records were stored securely in a locked cupboard in the ward office.

Medicines management

- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines and mostly stored medicines in line with the provider's policy.
- On Picasso ward we found one patient was prescribed and being administered eye drops and the date was written on the box, but there was no dispensing label. This meant that there was a risk that an error could occur while administering these medicines.
- On Picasso ward we reviewed 20 post rapid tranquilisation records for November 2019 for patients who were administered rapid tranquilisation. We found that on 5 occasions staff did not record pulse, temperature or blood pressure of the patient receiving rapid tranquilisation which did not meet the national guidance issued by National Institute for Health and Care Excellence and the provider's own policy. Rapid tranquilisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others and allow them to receive the medical care that they need.
- Managers told us that they now have a robust system to manage medication administration errors with the introduction of a medication error procedure. These were closely monitored by the ward managers and clinical manager.
- The service uses an independent pharmacy for the supply of medication and the pharmacist visited weekly to monitor the service.
- Medicines were prescribed appropriately meeting the Mental Health Act requirements. There were no gaps in administration records which provided assurance that medicines were being administered as prescribed including medicines prescribed to be administered on a when required basis.
- Medicine charts were paper based and supplied by the pharmacy supplier. These were stored securely and stationery was managed appropriately as per the providers policy.
- Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

- We saw that nursing staff introduced themselves to patients before offering them medicines, they explained what they were giving, and observed the patient take them.
- Printed information related to medicines prescribed was available to patients to help explain the indication and likely side effects. Medical staff reviewed medicines prescribed to patients on regular basis.
- Medicine charts reviewed by us provided assurance medicines were prescribed appropriately meeting the Mental Health Act requirements. A pharmacist visited the wards once a week to clinically screen prescriptions and advise medical staff when doses needed to be revised.
- The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.
- Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.
- The service had a contract in place with a local GP practice to monitor and manage patient's physical health needs. Patients were registered with this GP practice. A designated GP visited the service once a week. The practice nurse based at the service was responsible for carrying out regular physical health checks. Records reviewed by us provided assurance that patients were being monitored appropriately for medicines prescribed to them.

Track record on safety

- Between December 2018 and November 2019 there were 505 incidents on Picasso ward with an average of 42.08 incidents a month (ranging from 14 to 66incidents). Of the total number of incidents reported on the organisation's incident reporting system, the most common type of incident on Picasso ward was violence followed by security incidents.
- Managers told us that three staff on Picasso ward had been injured and had to take time off as a result, within the three months prior to inspection.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents to report and how to report them. Staff used an online incident reporting system. Staff reported serious incidents clearly and in line with trust policy.

Long stay or rehabilitation mental health wards for working age adults

Good 🟢

- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. the incident reporting system prompted staff to identify issues which met the criteria and staff gave patients and families a full explanation if things went wrong.
- Managers debriefed and supported staff after any serious incident. Staff could also attend reflective practice sessions facilitated by the psychologist where they could reflect on incidents.
- Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw minutes of management meetings that indicated these issues were discussed.
- Staff received feedback from investigation of incidents, both internal and external to the service, via email and through staff meetings.
- Staff met to discuss the feedback and look at improvements to patient care. Staff told us that they had met for debriefings after incidents had happened to learn lessons from them.
- There was evidence that changes had been made as a result of feedback. We found that care plans were put in place following incidents on Picasso ward.

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

Good 🟢

Assessment of needs and planning of care

- Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.
- Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We looked at a sample of 4 care records on the ward. Care plans were person centred, individual, personalised, holistic and recovery orientated. They reflected the needs of each patient and included a risk management care plan, a behavioural support plan, a physical health care plan including ongoing monitoring of patients' physical health.

- All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. A specialist practice nurse was available onsite to address physical health needs. The practice nurse supported ward staff to develop care plans for patients around their physical health.
- A general practitioner (GP) visited the ward weekly to see patients.
- Staff regularly reviewed and updated care plans when patients' needs changed.
- Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

- Staff delivered care in line with best practice and national guidance from organisations like the National Institute for Clinical Excellence (NICE). Evidence seen in the care files confirmed that the service followed NICE guidance when prescribing medication and in relation to psychosis, schizophrenia and depression in patients. Individual and group therapies were available, led by psychologists. Therapies offered included a cognitive behavioural therapy and exercise and mindfulness programme.
- Patients could access a range of therapeutic activities to support their recovery, improve daily living skills and enable independence. We saw occupational therapy care plans within the electronic patient records, which focused on recovery and rehabilitation. Occupational therapists were implementing evidence based, low level sensory interventions to help patients cope with emotional stress.
- Ward activities during weekdays included art and crafts, relaxation, walks, mindfulness, pool and gym exercise programmes. On evenings and weekends, materials were available on the ward, for patients to do with support from ward staff. Ward staff told us that they had a budget to facilitate activities on weekends. However patients told us there were activities every day except Saturday and Sunday.
- We saw a timetable of activities displayed on Picasso ward. This included a daily planning meeting and a weekly community meeting, as well as a variety of activity sessions and groups.
- An audit for activity engagement from June to November 2019 showed that most patients engaged in25 or more hours' worth of activities each week.

Long stay or rehabilitation mental health wards for working age adults

- Staff identified patients' physical health needs and recorded them in their care plans, supported by the practice nurse for the unit.
- Staff made sure patients had access to physical healthcare, including specialists as required. A GP attended the ward weekly and could make referrals to specialists if needed.
- Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.
- Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The practice nurse ran wellbeing groups to help patients to understand their physical health needs and live a healthy lifestyle.
- Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used outcome measures like Health of the Nation Outcome Scales (HONOS) where patients answered a series of questions about their health and wellbeing before and after treatment to determine the effectiveness of their treatment. Clinicians like psychologists and occupational therapists also used their own specialist outcome measures.
- For physical health conditions, we saw that staff used tools such as the Modified Early Warning Score (MEWS)which is a simple assessment that shows if somebody's physical health is stable or deteriorating.
- Staff used technology to support patients. A computer suite was available near the ward that patients could access. Patients were also able to access wireless internet throughout the service. Staff said they encouraged patients to access information about medication online.
- Staff took part in clinical audits, benchmarking and quality improvement initiatives. We saw discussions about clinical audits documented in Integrated Governance meetings.
- Managers used results from audits to make improvements.
- Psychologists told us they had audited the effectiveness of all the groups they ran.

Skilled staff to deliver care

- The staff on Picasso ward included the full range of specialists. This included administration, doctors, clinical psychologists, occupational therapists, registered mental health nurses and social workers. Other specialists available to all wards included the practice nurse who could provide support to staff and patients on physical health issues.
- Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.
- New staff received a comprehensive induction fromward staff and we saw that induction checklists were complete.
- Managers supported staff through regular, constructive appraisals of their work. At July 2019, 29% of staff on Picasso ward had had an appraisal, however the ward had recently opened so had many new staff who were yet to have an appraisal.
- Managers supported non-medical staff through regular, constructive clinical supervision of their work. Most ward staff on Picasso ward received monthly clinical supervision. At July 2019, 86% of staff on Picasso ward had received clinical supervision, with a target of90%.
- During the inspection, we saw supervision records that indicated all staff received supervision for four out of the last six months. For April, May, September and October, some staff did not receive clinical supervision. Managers said this was due to absence or sickness.
- Staff attended regular team meetings or received information from those they could not attend. Were viewed monthly staff meeting minutes for September, October and November 2019. These recorded discussions about issues on the ward and showed evidence of lessons learned.
- Staff were given the time and opportunity to develop their skills and knowledge. A range of training courses were available online for staff to complete and staff could apply for additional training related to the service. Staff received any specialist training for their role, such as phlebotomy.

Multi-disciplinary and inter-agency team work

- The ward had a multidisciplinary team with doctors, nurses, occupational therapists, psychologists and social workers who all worked together as a team to benefit patients. They used weekly multidisciplinary meetings to make sure patients had no gaps in their care. Each patient could attend every four weeks. We observed one multidisciplinary ward round at which a patient also attended. The consultant chaired the meeting and the team reviewed and discussed care

plans, risk and physical health issues with patients. Patients were offered a copy of their care plan at the meeting and could sign this if they wished. Family members could attend wards rounds with the agreement of the patient.

- The ward team invited care co-ordinators and representatives from external services to regular Care Programme Approach meetings and had effective working relationships with other staff from services that would provide aftercare following the patient's discharge.

Adherence to the MHA and the MHA Code of Practice

- Staff received and kept up-to-date with, training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.
- Care record files and online records were in order and easy to navigate. The Mental Health Act documentation was present and easily available on all the files were viewed.
- There was active involvement of the independent mental health advocacy (IMHA) service.
- Copies of up-to-date section 17 leave forms were kept in a file accessible in the nurses' office. The forms were comprehensive, clearly detailing the levels, nature and conditions of leave.
- Assessments of patients' capacity to consent to treatment were recorded at the point that medicine certificates were issued and reviewed. The certificates were reviewed in line with the provider's policy.
- Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice from the hospital's mental health act office, which employed two administrators. Ward staff knew who their Mental Health Act administrators were and when to ask them for support. We saw a mental health act administrator on Picasso ward who was auditing patient records to ensure the mental health act paperwork was correct.
- The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff told us they could access these records via their intranet system.
- Patients had easy access to information about independent mental health advocacy and patients who

lacked capacity were automatically referred to the service. Staff told us that advocates visited the ward at least weekly. We saw posters and leaflets on the ward about how to access advocates.

- Staff told us they explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We saw evidence in the notes that patients' rights had been read to them.
- Staff made sure patients could take section 17 leave(permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. The ward had a folder with each patient's name in it and whether they had section 17 leave and how much.

Good practice in applying the MCA

- Staff received and kept up-to-date with, training in the Mental Capacity Act and had a good understanding of at least the five principles.
- However ward staff tended to rely on doctors to make mental capacity assessments.
- Managers told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for Picasso ward between February 2019 to July 2019.
- There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access online via the service's intranet.
- Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we interviewed on Picasso ward told us that they would get information about this from the Mental Health Act office.
- Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.
- Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.
- When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Long stay or rehabilitation mental health wards for working age adults

Good ●

- The service monitored how well it followed the Mental Capacity Act acted when they needed to make changes to improve.

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

Good ●

Kindness, privacy, dignity, respect, compassion and support

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff were discreet, respectful, and responsive when caring for patients. We saw staff talking to patients in a respectful and caring manner at the time of the inspection.
- Staff gave patients help, emotional support and advice when they needed it. We saw patients asking staff for time when they needed it.
- Staff supported patients to understand and manage their own care treatment or condition. Patients were invited into ward rounds. In the ward round that we saw, staff explained treatments to patients and involved them in discussions.
- Staff directed patients to other services and supported them to access those services if they needed help. We saw staff in a ward round planning to refer patients for physical healthcare needs after discussing this with them.
- Patients said staff treated them well and behaved kindly. Patients we interviewed told us that all staff were very kind and helpful.•Staff understood and respected the individual needs of each patient. One patient on Picasso ward had difficulties with eating and the physical healthcare nurse specialist had made a care plan around this. She had also placed notices in the paper notes file on the ward to remind other staff to think about this aspect of the patient's needs.
- Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

- Staff followed policy to keep patient information confidential. All notes stored electronically were password-protected. Any paper notes were kept in files within a lockable cabinet in the ward office.

Involvement in care

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

Involvement of patients

- Staff introduced patients to the ward and the services as part of their admission. We saw staff showing a newly admitted patient round the ward and introducing them to patients and other staff. We saw the Picasso ward handbook that all new patients received on being admitted to the ward. This was co-written with service users and included basic information about the ward, care plans, the ward's model of care, daily routines, rights on the unit, smoking cessation, activities, staff available, names of managers, complaints process and where to find further information such as the mental health act information.
- Staff involved patients and gave them access to their care planning and risk assessments.
- Staff made sure patients understood their care and treatment. Patients were always invited to attend their care programme approach (CPA) reviews and ward rounds but sometimes chose not to attend or were not well enough to attend. Parents and carers were also invited to CPA reviews.
- Staff involved patients in decisions about the service, when appropriate. Picasso ward had a patient representative who attended a regular People's Meeting with managers to talk about patients' views on the ward.
- Patients could give feedback on the service and their treatment and staff supported them to do this. There were weekly community meetings on Picasso ward and patients could raise concerns at these meetings. We saw a You Said-We Did board on the ward and it was clear staff had acted on patient suggestions.
- Staff made sure patients could access advocacy services. Staff told us they encouraged patients to speak with advocates who came to the ward and explained to patients how to complain if they were unhappy with services.

Long stay or rehabilitation mental health wards for working age adults

Good ●

- Staff informed and involved families and carers appropriately.
- Staff supported, informed and involved families or carers. Staff told us they hold a quarterly carers' group. We saw a carers' newsletter in the reception areas of the hospital, which described activities that had been happening with patients and provided information about different interventions. The newsletter included an internet link to a feedback survey to collect views about the service.
- A booklet and other information about events, were available on the hospital website for families and caregivers.
- Staff helped families to give feedback on the service via carers meetings and also offered families the change to give feedback via individual meetings with ward staff.
- We saw that carers were given information on how to find the carer's assessment via the hospital website.

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

Good ●

Access and discharge

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Bed management

- Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The consultant psychiatrist on Picasso ward led the process for admission and discharge.
- Picasso ward's average length of stay was 567 days at July 2019.
- Managers and staff worked to make sure they did not discharge patients before they were ready.
- The data provided to us prior to our inspection stated that on average bed occupancy on Picasso ward was95.2% between February 2019 to July 2019.

- Picasso ward took on average 4 days to assess patients after referral (the service's target is 2 days) and an average of 53 days from assessment to initial treatment.
- When patients went on leave there was always a bed available when they returned.
- Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. In October 2019 a patient had been moved from Picasso ward to the Psychiatric Intensive Care Unit for the safety of other patients on the ward.
- Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

- The only reasons for delaying discharge from the service were clinical or a need for alternative, suitable accommodation. There were no delayed discharges on Picasso ward at the time of inspection.
- Staff carefully planned patients' discharge and worked with care managers and care coordinators to make sure this went well.
- Staff supported patients when they were referred or transferred between services. The service followed national standards for transfer.

The facilities promote recovery, comfort, dignity and confidentiality

- Each patient had their own bedroom, which they could personalise. Bedrooms were ensuite. Patients had a secure place to store personal possessions. We saw a small lockable safe in patient rooms that we inspected.
- Staff used a full range of rooms and equipment to support treatment and care. There were enough therapy rooms on the ward. Outside the ward environment patients could access therapy rooms, a computer room, a recovery college, a hairdresser and a gym.
- The service had quiet areas and a room where patients could meet with visitors in private.
- Patients could make phone calls in private. Ward telephones were available for family and friends to contact staff and service users on the ward. Staff told us that ward mobile telephones are provided after individual risk assessment.
- The service had an outside space that patients could access easily, however staff told us that this was closed at 10.00 pm to protect patients. It was unclear whether this was a blanket rule that applied to all patients or individuals at risk.

Long stay or rehabilitation mental health wards for working age adults

- Patients could make their own hot drinks and snacks and were not dependent on staff.

Patients' engagement with the wider community

- Staff made sure patients had access to opportunities for education and work, and supported patients to access these. There was a recovery college within the hospital that helped patients to access external education opportunities. This included a range of activities for patients to help their recovery, including groups such as a vocational development group, community group, gym, recovery care, goal-setting, sensory and relaxation group, psychoeducation and cooking.
- Staff told us that one patient was due to start work in a charity shop locally in the week following the inspection. Most of the groups were held outside the ward in a recovery corridor, which included facilities including an activities of daily living kitchen, computer room, hair salon, patient library, quiet room and a gym. Staff told us that one patient worked in the kitchen with support from occupational therapy staff and another patient was due to start a job in a local charity shop.
- We did not see extensive activities available for patients who could not leave the ward or for evenings and weekends. The activities timetable for weekends that we saw on the ward indicated that activities could be nursing led or self-directed, although it was not clear which activities actually happened and when. Staff told us that equipment was available on the ward for games or art-based activities and that there was a budget for weekend activities, such as trips outside the hospital. In the evenings, patients could sometimes engage in a computer club, karaoke or a movie night. It was not clear when or how often these activities occurred.
- Staff helped patients to stay in contact with families and carers. Ward telephones were available for relatives to call patients on. Patients could access the internet on their mobile telephones, via a wireless network, and could maintain contact with family and friends this way.
- Staff encouraged patients to develop and maintain relationships both in the service and the wider community through family visits and time on leave.

Meeting the needs of all people who use the service

- The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Staff could access interpreters if required.
- Staff made sure patients could access information on treatment, local service, their rights and how to complain. We saw signs on the ward showing how to do this and patients and visitors were given leaflets about the ward which included information about complaints, treatment and how to access advocates and other useful organisations.
- The service had information leaflets available in English. Staff said they could obtain leaflets in languages other than English if they needed to.
- Managers made sure staff and patients could get help from interpreters or signers when needed.
- The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients we interviewed told us that food is good most of the time. Some spoke very highly for the food. One patient said she can get her own food if she wanted.
- Patients had access to spiritual, religious and cultural support. A dedicated room was available for chaplains to meet with patients. A female chaplain visited the ward once a week and could make contact with representatives from other religions if patients wanted.

Listening to and learning from concerns and complaints

- Patients, relatives and carers knew how to complain or raise concerns.
- The service clearly displayed information about how to raise a concern in patient areas. On Picasso ward, there were posters and information leaflets for patients telling them they could complain and how to do so. Most of the patients we spoke with told us they were confident about making a complaint and knew how to do so.
- Staff understood the policy on complaints and knew how to handle them.
- Managers investigated complaints and identified themes. On Picasso ward, data we received prior to the inspection showed recent complaints were commonly about medication errors and staff behaviour.

Long stay or rehabilitation mental health wards for working age adults

Good ●

- According to data we received before the inspection, Picasso ward received 17 complaints between November 2018 to July 2019. Three of these were upheld, four were partially upheld and eight were not upheld. two were still under investigation.
- Staff protected patients who raised concerns or complaints from discrimination and harassment.
- Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.
- Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us they discussed complaints in staff meetings. We saw evidence of this in staff meeting minutes that were viewed.
- The service used compliments to learn, celebrate success and improve the quality of care. Picasso ward received 7 compliments during the last 12months from September 2018 to September 2019.

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

Good ●

Leadership

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff told us that the ward manager was always visible when at work and available to offer them support. Senior managers had visited the wards.

Vision and strategy

- All staff knew and understood the service visions and values and applied them to their work. Staff spoke positively about senior management in the service.

Culture

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

- On Picasso ward we saw in staff meeting notes that potential conflict had been addressed and resolved. A meeting in June 2019 had encouraged staff to discuss the prevention of use of derogatory language towards colleagues.

Governance

- Our findings from the other key questions demonstrated that governance processes mostly operated effectively at ward level and that performance and risk were mostly managed well. However we found that rapid tranquillisation records were not fully completed which suggested these may not be monitored effectively.
- On Picasso ward we saw staff meeting minutes that showed how improvements to the environment checklist had been made.
- Doctors told us the service was planning to engage in the Accreditation for Inpatient Mental Health Services(AIMS) which is overseen by the Royal College of Psychiatrists. Services can use this to ensure they meet high standards of care.

Management of risk, issues and performance

- Managers attended a monthly Integrated Governance Meeting We saw Integrated Governance Meeting minutes from August 2019 that noted how Picasso ward had raised a concern about a high rate of self-harm on the ward. This had been discussed in the meeting. Another set of minutes from June 2019 showed how absconsion rates and prescription errors had reduced.
- All managers completed a benchmarking document (a document that compares their performance with other teams about waiting times, outcomes, discharge).

Information management

- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Managers told us that information was disseminated through monthly management meetings. This was evident from the minutes of the IGMs.

Engagement

- Staff engaged actively in local and national quality improvement activities.
- The psychology department had engaged in two projects with the National Institute for Clinical

Long stay or rehabilitation mental health wards for working age adults

Excellence (NICE); one was about the use of the gym to improve patients' wellbeing and the other was about psychology work that was helping patients to manage intense emotions.

- The carers' group in the hospital involved members of the local community, including charities like Mind, Families Anonymous and Alcoholics Anonymous, who had been invited to talk about their services.

Learning, continuous improvement and innovation

- All staff were committed to continually improving services and had a good understanding of quality improvement methods. Leaders encouraged innovation and participation in research.
- The staff team showed a commitment to continued improvement through using quality improvement methods.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that medicines for individual are labelled for individual patients as per providers own policy. (Regulation 12 Safe Care and Treatment)
- The provider should ensure physical observations were being recorded post rapid tranquilisation (RT)administration. (Regulation 12 Safe Care and Treatment)

Action the provider SHOULD take to improve

- The provider should ensure that the maintenance systems be reviewed to ensure issues like the broken lock door to the de-escalation room were identified and repaired promptly.
- The provider should support staff to review the few occasions when patients were secluded in their bedrooms and how potential risks to patient safety can be minimised should this need to take place in the future.

- The provider should ensure that staff know what to do if a fob (electronic locking system) system failed or if the unit needs to be locked using another system.
- The provider should ensure that physical health checks following rapid tranquilisation are effectively audited.
- The provider should ensure there were lessons learnt in relation to incidents relating to medication errors to prevent a reoccurrence of the same incident.
- The provider should ensure that staff on all wards receive adequate support and debriefing following a serious incident.
- The provider should ensure that all staff follow the infection control policy with regards to hand-washing
- The provider should ensure there are suitable, readily available hand washing facilities for staff in all areas of Picasso ward to prevent the risk of cross infection.
- The provider should ensure there are easily-accessible staff storage facilities during the shift.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines for individual use were not labelled for individual patients as per providers own policy. Staff did not always complete physical health checks for patients who had received rapid tranquilisation medicines. This was a breach of Regulation 12(2) (b) (g)