

Cygnet Surrey Limited

# Cygnet Hospital Woking

## Inspection report

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

### Ratings

#### Overall rating for this location

Good



Are services safe?

Good



Are services well-led?

Good



# Summary of findings

## Overall summary

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

- The service provided safe care. The ward environments were safe, clean and well furnished. The wards had enough nurses and doctors. Staff assessed and managed risk well. They analysed and minimised the use of restrictive practices through clinical governance, they managed medicines safely and followed good practice with respect to safeguarding.
- Clinical rooms and clinical medical devices were well managed and physical health monitoring had significantly improved.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audits to evaluate the quality of care they provided.
- Patients reported that staff treated them with compassion and kindness, respected their privacy and dignity, and understood their individual needs. They actively involved patients, families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

# Summary of findings

## Our judgements about each of the main services

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

# Summary of findings

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# 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 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 and a male acute ward for working age adults which opened in July 2021. Cygnet Lodge Woking was inspected at the same time as this inspection but is rated as a separate location.

The same leadership team and registered manager oversee both locations.

There are three core services at Cygnet Hospital Woking delivered across four wards with a total of 57 beds.

- Oaktree ward – 11 bedded female only forensic inpatient / low secure ward
- Greenacre ward – 18 bedded male only forensic inpatient / low secure ward
- Acorn ward – 10 bedded female only psychiatric intensive care unit
- Picasso ward – 21 bedded female only acute ward for adults of working age

We carried out this focused inspection because at our last inspection in 2022 we found areas of concern continued to remain and we were concerned that actions had not been implemented at ward level to maintain the safety of the patients on Picasso Ward. In addition to this, information of concern had been escalated to the Care Quality Commission in relation to patients bringing dangerous items onto the ward.

Following the 2022 inspection the hospital responded immediately to the concerns and the hospital provided the CQC with an action plan to address all the identified concerns. We monitored the progress of the action plan during 2022 with regular engagement meetings.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met the required standards.

This report only covers our findings in relation to the key questions: Safe and Well led which contain the previous concerns. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

### What people who use the service say

We spoke with ten patients on the ward who gave us an overall positive view of their experiences on Picasso. They felt the staff treated them well and the atmosphere in the wards was relaxed and safe. The patients were able to identify the difference between the upstairs environment and the downstairs area of the ward stating that it was busier downstairs and calmer and more peaceful upstairs.

# Summary of this inspection

Patients told us they felt involved in their care planning and decision making and were able to be supported by their family members in the care planning process.

Patients that had been newly admitted to the ward felt they had the issues with bringing dangerous items on to the ward explained to them when they were admitted and told us they were searched regularly when they were coming on and off the ward. The patients felt this was a suitable restriction and were understanding of the reasons why staff had to do this to maintain safety of the ward.

The patients told us that staff were available and there was always lots of therapeutic activities to take part in if they wanted to. They told us the food was good, that staff managed incidents well and that the doctors were available and supported their recovery journey.

All patients felt the wards were regularly cleaned and their rooms were comfortable with suitable fixtures and fittings.

## How we carried out this inspection

The team that inspected the hospital comprised of three CQC inspectors and one specialist advisor. Before the inspection visit, we reviewed information that we held about the hospital.

During the inspection we completed the following activity:

- visited Picasso ward and observed how patients were being cared for by staff
- spoke with ten patients
- spoke with over 15 members of staff including Hospital Manager, Director of clinical services, Ward manger, nurses, support workers and occupational therapists.
- reviewed six sets of individual patient care plans and eleven sets of medication charts on the electronic system
- observed staff handover meetings and multi-disciplinary flash meetings
- reviewed a range of documentation relating to the running of the wards

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

# Our findings


## Overview of ratings


Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Not inspected	Not inspected	Not inspected	Good	Good
Overall	Good	Not inspected	Not inspected	Not inspected	Good	Good

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

Good 

Safe Good 

Well-led Good 

## Is the service safe?

Good 

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

### Safe and clean care environments

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

#### Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of the ward areas and removed or reduced any risks they identified. We checked the audit against what risks were present in the different areas of the ward. We found that rooms matched the audits and risks were identified and mitigated.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff had regular emergency response training which identified response to ligature incidents and understood the importance of active observations when supporting the patients. The ligature audits had identified heat maps for the ward which were easily visible in the ward office and described mitigation for the ligature risks including staff observations of the area.

The provider had a compliance team that was responsible for carrying out a regular security walk around the ward to identify any new ligature points. Findings were then communicated to staff via the ligature heat map and the ward manager.

There was an allocated security nurse at the start of each shift who ensured that security items such as radios, alarms and keys were working effectively and other items such as cutlery items, which could pose risk, were safe and accounted for.

Staff ensured all risk items were stored securely. Patient items that could pose a risk were locked securely in a cupboard near the entrance to the ward. We observed patients returning from accessing the community using the locker to store risk items that could not be brought on to the ward.

On this inspection we found that there was a clear ligature heat map in the staff office and the staff were aware which location the photos were referring to. The ligature heat map clearly identified higher risk rooms and also the location of all the ligature knives. The staff we spoke to were knowledgeable of where the ligature points were on the ward. They were also aware of the mitigation needed to reduce the risk of harm to patients and what action they would take if a patient was self-harming using a ligature. Staff gave examples of how items had been used as ligatures and how the hospital had addressed these risks. Staff were able to list high risk items and described how they individually risk assessed patients' access to these items.



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

Good 

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff could observe patients in all parts of the wards. Apart from patients' bedrooms, there were CCTV cameras on the wards and outside areas, such as gardens, that were patient accessible. There were parabolic mirrors which covered blind spots along corridors.

The ward was female only and complied with guidance for mixed sex accommodation. The ward was in the process of being upgraded at the time of the inspection. The hospital had identified that the size of the ward was operationally challenging to manage safely. The organisation had decided to split the ward into two smaller wards on two separate levels. This building work was ongoing during the inspection. We reviewed the rationale for this change and discussed the benefits of the split of the ward and felt this was a suitable improvement and would benefit the patient group.

Environmental risks were discussed and reviewed every day in the senior management team flash meeting and compliance issues such as the training of staff in therapeutic observations were discussed, to ensure the hospital had dynamic oversight of staff training in relation to the safety of the ward.

## Maintenance, cleanliness and infection control

Ward areas were clean and domestic staff made sure cleaning records were up-to-date and the premises were kept clean and free from infection.

We checked the patient bedrooms and found them to be in a good state of maintenance with anti-ligature fixtures and fittings and all bedroom furniture was in good order.

Staff followed infection control policy, including handwashing. We saw that adequate signage was in place across the ward and there was personal protective equipment available for all staff. Staff were aware of the current status of personal protective equipment required and were happy with the hospital's approach to supporting the risks from Covid-19.

Covid 19 remained a standing agenda item on the daily senior team flash meeting which meant the hospital had global oversight and discussed patterns of local outbreaks to raise awareness within the staff team poster.

## Clinic room and equipment

The clinic room was fully equipped, there was accessible resuscitation equipment and emergency medication. Nurses completed a thorough medication management checklist, including a clinic room check, at the end of every shift and handed it over to staff arriving for the next shift. The manager also carried out a weekly clinic room audit.

As it had been an issue in the previous inspection we checked the management of all clinical medical devices in the clinic room. We found that all clinical medical devices including blood glucose monitoring machines had regular audits in place to ensure they were checked on a daily basis and calibrated when required. There were no gaps in monitoring.

## Safe staffing

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

## Nursing staff

The service had enough nursing and support staff to keep patients safe. Managers used a staffing 'ladder' to calculate staff numbers for the number of patients on the wards. The service therefore knew how many staff it needed on each shift to keep patients safe. The daily multi disciplinary flash meeting reviewed staffing across the whole hospital and moved staff when necessary between the wards to support safety and patient engagement.

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

Good 

The ward manager was able to increase staffing levels to meet patient need. For example, if a patient was identified through risk assessment as requiring one to one support to ensure their safety or the safety of others then staff was made available by the Hospital Manager. We found that when necessary the ward manager had booked additional staff to meet the needs of patients placed on increased observations

There were two mental health nurse and four support worker vacancies at the time of the inspection with two of these vacancies already recruited to. Managers used bank and agency staff to maintain the staffing levels and had protocols in place for short-staffed shifts. Regular agency staff were used to ensure the service maintained consistency.

Agency usage had improved over the three months prior to the inspection, with nurse vacancies recruited into by international nurses. The hospital was having twice weekly interview days to recruit into the support worker vacancies. When we discussed recruitment with the Hospital Manager, they recognised staff vacancies had been a top risk in the hospital risk register and they had pursued a proactive recruitment and staff retention strategy and they felt it was a significantly improved area and could be removed from the Hospital risk register.

The ward manager who was a qualified nurse also covered shifts when available. Junior doctors, who were available on the ward, supported the ward when necessary.

Patients said that they had regular one to one sessions with their primary nurse and rarely had their escorted leave or community access cancelled, even when the service was short staffed.

Patients and carers told us that staff were always available to answer their questions and offer support. Care records included daily progress notes and records of interviews with patients. We observed that staff were patient, positive and calm when interacting with patients.

## Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the wards quickly in an emergency. 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.

The ward had a full time consultant psychiatrist and junior doctor dedicated to Picasso ward who was available Monday to Friday between 9am and 5pm. The service also had medical cover available out of hours, who was available on an on-call rota.

## Mandatory training

**Staff completed and kept up to date with their mandatory training.**

Training compliance rates were consistently above the service's 85% target. At the time of the inspection the average rate of completion of training was 94% across all areas. The mandatory training programme was comprehensive and met the needs of patients and staff. All nursing and support staff completed additional training in observation skills and specialised training was also available to cater for the service's patient group, such as search training, working with people with personality disorders and some specific clinical training for nurses which had been co-ordinated with the local NHS trust. These mandatory and specialised trainings were also available to agency staff workers.

The training department sent a weekly training report to the Heads of Department and staff were given one week to complete their outdated modules and if their training compliance was not 100% by the following Monday then they receive a letter of concern drafted and signed by the Hospital Manager.

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

Good 

Compliance with training was also discussed every day in the morning flash meeting and any concerns with access to training was highlighted with the senior management team.

## Assessing and managing risk to patients and staff

**Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed.**

We saw a clear process in place for the decreasing of patient observations which was reviewed by the multi-disciplinary team in ward review meetings.

The ward used an electronic notes system which identified and used a section called “managing my risk”. We found this was being implemented consistently and the care plans generated by this were regularly reviewed with the patients.

It remained a challenge to search the informal patients returning from time outside the ward but staff kept a record of this. Staff continued to discuss the requirements for searching with all patients whenever they were exiting and re-entering the hospital building. All patients were searched when they returned to the hospital from leave and any contraband or restricted items were removed and stored in lockers. Staff told us it was sometimes difficult to search patients as soon as they returned to the hospital as patients were usually informal and could leave the ward and return without supervision.

All staff were able to explain how they would search a patient upon return from leave. Staff were aware of the policy on searching patients and patients reported this was happening consistently even though they were not always happy about it.

All staff were trained in searching, new staff were trained in the induction, with an annual update. We also saw evidence that this was completed as part of the agency staff training.

Staff had to complete observational competency training which was designed to support therapeutic observations with patients. This taught the management of observations through engagement and not simply watching and recording. This was reflected in our observations of the staff engagement with the patient group which was positive and we observed lots of positive communication during therapeutic observations.

The ward had to identify which patients were going out of the ward in the flash meeting each day. When they returned staff would collect them from reception and carry out a personal search and ensure their bags were searched.

All staff we spoke with had a really good understanding of observations and why patients required observations.

We reviewed incident logs and saw that when physical restraint was used the rationale was clearly defined and all staff involved in the restraint were identified, it was clearly detailed what support was offered to the patient and the staff following the incident. We saw that risk assessments were updated following these incidents and care plans were updated if necessary.

## 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.**

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

Good 

## Management of patient risk

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff followed procedures to minimise risks where they could not easily observe patients, including allocating patients to specific bedrooms based both on physical health and mental health risk assessments.

We were told by staff that patients were risk assessed on admission for a history of self-harm using a ligature. This dictated which room a patient would be allocated to in the current configuration of the ward. As more complex patients would remain on the lower floor so enhanced observations could be managed more easily if required. In the plans for the separation of the wards this would be more easily managed as the wards will be two completely separate units.

We reviewed six patients' care records. In all of the six patients' records there were assessments of individual risk for managing each patient's safety in the hospital environment and identifying suitable bedrooms with reference to the environmental ligature risks. The service had a procedure in place to manage this risk.

Levels of restrictive interventions were low and / or reducing and 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 and unless absolutely necessary did not use prone restraint. Prone restraint is when an individual is placed face down on the ground.

Staff understood the Mental Capacity Act 2005 definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation and rapid tranquilisation physical health monitoring and follow up was happening as per guidance.

## Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The hospital had regular two weekly meetings with the Surrey County Council safeguarding advisors. This ensured that the hospital was not stand alone when it came to safeguarding and were working alongside the local authority to action, reports and seek advice quickly and efficiently.

The hospital had a safeguarding log and tracked and audited safeguarding referrals when they were made. All new safeguardings were reviewed on a daily basis in the hospital flash meeting and actions were allocated to specific members of the senior management team to ensure that they were addressed.

Staff kept up to date with their safeguarding training and the training rate was 96% of the staff team at the time of the inspection. There was a system to alert managers when staff needed to complete or refresh their training.

Staff knew how to make a safeguarding referral through the electronic system and who to inform if they had concerns. Managers agreed the process for notifying about medication errors with the local authority.

Senior managers took part in serious case reviews and made changes to the hospital based on the outcomes.

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

Good 

## Staff access to essential information

**Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.**

Patient notes were comprehensive and all staff could access them easily through the electronic system.

Staff completed patient records using the service's electronic record system which contained clinical notes, risk assessments, care plans, mental capacity documentation, Mental Health Act documentation and information on patients' physical health.

All staff, including bank and agency staff, could access the electronic records and the records were stored securely.

## Medicines management

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

During the previous inspection we found that the medication room temperatures were not effectively managed, we found this had been resolved and clinic room temperatures were effectively audited and relevant action taken when required.

During the previous inspection we also found that blood glucose monitoring equipment was not effectively calibrated and aligned with appropriate care plans for diabetic patients. During this inspection we found that the physical health care nurse and the clinical nurses on Picasso had worked hard to ensure that effective systems were now in place for the calibration and regular checking of blood glucose monitoring machines and that this was properly documented. We found that in addition to the regular calibration of blood glucose monitoring equipment there were now clear management plans in place for diabetic patients and patients admitted with low BMI in line with national guidance.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We found that these processes were completed in line with the provider's policy and that there were no gaps in recording. We reviewed the electronic medication management systems on the ward and found that staff managed medication safely and securely.

Medical staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Doctors reviewed patients' medication on a weekly basis during care review meetings or as required if there was a change in the patient's presentation.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. All medication and prescribing documentation were stored in the clinic room which was kept locked. Controlled drugs were managed in line with national guidance and the hospital had a nominated controlled drug accountable officer.

The service used an external pharmacy service to provide oversight of medication and documentation. The pharmacist supplied a weekly report for managers.

The service ensured people's behaviour was not controlled by excessive or inappropriate use of medicines. We found that following rapid tranquilisation patients' physical observations were monitored effectively and when patients refused this was fully documented in their clinical notes.

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

Good 

## Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. The service had recognised there had been a time lag in reporting incidents and accidents externally, so they had implemented a tracking system which was completed at each daily flash meeting. Actions were allocated out to individual members of the senior clinical team to ensure that notifications to the local safeguarding authority and to the Care Quality Commission happened in a timely way.

Managers investigated incidents such as medication errors in line with the service's policy. Nursing staff involved in medication errors completed a fresh competency assessment and wrote a reflective piece for personal learning.

Staff understood the duty of candour. They were open and transparent. They gave patients and families a full explanation when things went wrong.

We saw evidence that lessons learned were shared in the staff bulletins staff meetings. Staff were aware of recent incidents that had taken place across the hospital and within the Cygnet hospital group.

## Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

## Leadership

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

The hospital had an experienced and stable leadership team. The hospital manager moved to the hospital in 2021. They were previously hospital manager at another independent sector hospital. The clinical manager had previous experience both in nursing and in management and had been at the service for many years.

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the service they managed and spoke enthusiastically about it. Leaders were visible within the service and were approachable for patients and staff.

The Hospital manager, deputy hospital manager and clinical services manager attend the morning flash handover meetings every day they were at the site. Staff said that leaders were very supportive. They told us that leaders at the service had an open-door policy and were always available and willing to speak to them. Staff felt able to raise any matter or concern with leaders. They gave examples of suggestions they made to leaders and the positive responses they received.

The senior management team worked closely together and there were regular monthly clinical governance meetings. Various committees, such as patient safety committee, fed into the clinical governance framework meetings.

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

Good 

The Deputy Hospital Manager and the ward manager conducted regular audits reporting back to the Hospital manager.

## Vision and strategy

**Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.**

The philosophy of the service was collaborative and followed a person-centred approach. The leadership team had successfully communicated their vision for the service to frontline staff who spoke enthusiastically about teamwork, both with each other and with patients.

There was a clear, flattened management structure consisting of a Ward Manager, Clinical Manager, Deputy Hospital Manager and the Hospital Manager. The staff described feeling nurtured in their roles and supported to develop when they and their line managers felt it was appropriate.

Staff were aware of Picasso Ward's development plans and felt involved in the improvements to the ward environment. The overall plan was to separate the large 21 bedded ward in to two smaller more manageable wards both on their own floor so staff and patients would no longer be spread across two floors.

Staff spoke very positively about the changes and the benefits they would bring both to patient and staff safety. We reviewed the projected plans and discussed them with the Hospital management team and it felt like the process had been collaborative, not only with the staff of the ward but also with external commissioners who had been involved in the discussions around ward ligature safety design.

Staff felt that there had been significant improvements in safety following the last inspection and felt that they had been involved in that process.

## Culture

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

Staff knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation. Staff told us of occasions they had to raise concerns around HR issues with the senior management and had not felt victimised afterwards and were confident they could raise concerns again.

Leaders encouraged compassionate, inclusive and supportive relationships among staff. Leaders shared lessons learnt when something went wrong and told staff about any actions taken to prevent the same happening again. We saw that the hospital had developed a Woking Weekly newsletter that was sent to all staff and included clearly presented information on incidents and lessons learned that had happened locally and across the Cygnet organisation.

Staff spoke positively about working on the ward and said they were proud of the service, the team spirit amongst staff and the progress patients made. The ward was described as both challenging and rewarding but never boring.

Staff reported good morale and were happy in their roles. We observed supportive and cohesive team working and the atmosphere appeared relaxed and encouraging. This was confirmed by staff.



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

Good 

Staff received training and support and had opportunities for development and career progression. Leaders recognised staff success within the service, for example through staff awards programmes.

## Governance

**Our findings from the other key questions demonstrated that governance processes were robust and operated effectively.**

**Leaders had developed a well-understood, comprehensive governance structure. Staff took minutes and actions from meetings to the monthly governance meeting, so leaders had full oversight, including over statistics and data relating to the Mental Health Act 1983.**

When we discussed key performance information with the ward manager, they were aware that information regarding care plan audits was extracted from the electronic notes system. The manager was required to provide a weekly or monthly return on human resources related concerns including the staffing and sickness of the wards. The ward manager had a good handle on the performance issues relating to the running of the ward and where the high level risks were.

The ward team had access to the information they needed on the ward computers which supported them to provide safe and effective care and used that information to good effect.

We observed staff maximise shift-time on direct care activities as opposed to administrative tasks. Staff were engaged with patients and supporting them in daily activities. Patients and carers confirmed this.

Occupational Therapy staff had developed a comprehensive therapy timetable and collected data in relation to how many hours each patient had direct contact with therapy services and fed this into the clinical governance structure.

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. To improve engagement with patients loved ones the hospital had a weekly friends, family and carers drop in telephone call which fed directly into the clinical governance structure

Managers engaged actively other local NHS health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

## Management of risk, issues and performance

**Teams had access to the information they needed to provide safe and effective care and used that information to good effect.**

There was an appropriate clinical governance structure in place to ensure information and risk was escalated and managed in a timely manner. The governance structure tracked data relating to incidents and accidents, use of restraint and rapid tranquilisation to ensure the hospital were aware of the most recent incidents and were reviewing these regularly.

The ward manager and the clinical manager confirmed that they could submit items to the hospital risk register and were able to give examples and describe the process involved. We could see this was discussed in the clinical governance meetings and that the hospital was taking appropriate action in relation to the identified risks.



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

Good 

Staff confirmed that they received feedback from incidents and complaints and that lessons learnt from other wards was shared with them at team meetings, via emails and within supervision and team days. All staff we spoke with could describe recent incidents on their wards and managers could describe lessons shared across the Hospital. This process was also replicated in the clinical governance structure and we found lessons learned were shared in an accessible format across the entire staff team in the weekly staff newsletter.

## Information management

**Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.**

Staff had access to the equipment and information technology (IT) needed to do their work. The electronic system containing patient information worked well and all staff could access the system. Leaders ensured all IT systems were backed up and 24 hour IT support was available for staff. The ward also used an electronic medication management system which had improved the administration of medicines to patients by minimising staff errors.

The ward manager had systems and dashboards in place to support them in their role. This included information on staffing, supervision and appraisals, training and hospital performance data.

Leaders and staff received helpful data each day, which was presented by the quality assurance team in the daily flash meeting where it was reviewed and supported the multi-disciplinary team to adjust and improve performance as necessary.

## Engagement

**Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.**

There was a strong focus on continuous learning and improvement at all levels of the organisation.

Staff said that they went to other hospitals within the Cygnet hospital group to gain experience and they received support from external colleagues. The Cygnet hospitals would also carry out their own quality assurance inspections regularly and feedback the findings into the clinical governance structure.

The staff received training specific to the patient group. Leaders visibly encouraged continuous improvement with regular quality walkarounds when members of the senior management team visited all areas of the hospital, talked to staff and patients, and checked documentation.

Areas for improvement were noted and leaders produced an action plan which they followed up in governance meetings.

The hospital used a “you said, we did” format for supporting patient feedback, this was taken on a week by week basis and fed into the clinical governance structure to ensure actions were allocated to staff to follow up. In addition the hospital had a separate annual service user and families and carer satisfaction survey.

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

Good 

## Learning, continuous improvement and innovation

The hospital had developed comprehensive plans based on Commissioner's and internal organisational quality assurance inspections to separate Picasso ward into two separate smaller wards. These plans had been put into action in the weeks preceding the inspection. The rationale for the separation of the two wards was based on improving the safety and experience of the patients and the staff within Picasso ward.

The hospital had developed a role for a patient to support the ward as an activity coordinator. The employed patient supported the patient group with organised activities on the ward and was responsible for chairing the weekly community meeting and ensuring the patient voice was carried through to the governance meetings and that patient requests were followed up. The purpose of this role was also to offer supportive sessions on healthy living, nutrition, and fitness.

The hospital also employs a registered general nurse to support the ward with all physical health related care issues and advice as well as triaging the GP clinic, managing the smoking cessation programme and providing regular presentations on different physical health concerns for patients and staff for example diabetes management and well woman related concerns.