

Good 

Community Care Trust (South West) Limited

Cypress Hospital

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
1-4939460453	Cypress Hospital	Cypress Hospital	TQ122PW

This report describes our judgement of the quality of care provided within this core service by Cypress Hospital. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Cypress Hospital and these are brought together to inform our overall judgement of Cypress Hospital.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Good 

Are services safe?

Good 

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 / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Cypress Hospital as good because:

- Staff treated patients with compassion, kindness and supported their individual needs. Staff involved patients and those close to them in decisions about their care, treatment and changes to the service. The staff group were very engaged with and positive about working with the patients. The person centred nature of the service ran through the care plans, face to face interactions and the language used in handovers and meetings
- Staff completed thorough assessments of patients which were holistic and used these to inform individualised care plans for patients. Staff ensured that all assessments, including risk assessments and care plans were updated regularly
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care
- The service provided treatment and care for patients that followed a recovery focused model. Staff supported patients with their physical health and encouraged them to live healthier lives
- Staff had appropriate training that enabled them to meet the needs of patients and keep them safe
- Cypress was a single site service which accepted male and female patients. It was able meet the guidance on same sex accommodation by accommodating men and women in separate corridors.
- The team included or had access to the full range of specialists required to meet the needs of the patients in the service
- Staff understood their roles and responsibilities under the Mental Health Act 1983, the Mental Health Act Code of Practice and the Mental Capacity Act
- The service took account of patients' individual needs. Staff helped patients with communication, advocacy and cultural support. Patients had their own bedrooms where they could keep personal belongings safely.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results. The service shared these lessons with all staff.
- The culture at the hospital was positive, most staff felt supported and respected by managers.

However:

- Although the service had recently moved to a purpose built environment that was designed to minimise ligature risk, there were risks posed by several ligature points that were not being managed fully. When made aware of these the senior management team immediately put in place a plan to address the risks.
- Staff were not able to easily see all parts of the service, when we discussed this with managers they made arrangements for convex mirrors to be put in place to ensure staff could see all areas.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We rated safe as **good** because:

- The service environment was clean and well maintained.
- Patient's risk assessments were of a good quality and were reviewed and updated regularly in care plans, during handovers and other meetings.
- Staff completed appropriate observations of all patients. Patients received higher levels of observation when required. The team consistently adhered to the services risk and observation policies.
- There were adequate numbers of staff on duty at all times. The service had a stable workforce team, and turnover was low.
- Staff knew how to raise incidents and there are processes in place to feedback learning. Debriefing sessions were undertaken following incidents and information was shared across the team. Staff were aware of and involved in changes and improvements in practice because of incidents.
- Staff had received safeguarding training and understood the process for raising a concern.
- Staff had access to notes from Cypress and those from the local mental health provider which ensured always had the information they required to support the delivery of patient care
- Medicines management was robustly audited and overseen by a pharmacist from the local mental health trust.

However:

- Although the service had recently moved to a purpose-built environment that was designed to minimise ligature risk, there were some ligature points that were not fully mitigated. This was raised with the senior management team at the time of the inspection and the service immediately actioned a plan to mitigate the risk of ligature points.
- Staff were not able to easily observe all parts of the service. This was raised at the time of the inspection and the manager raised a request to put in place to mount convex mirrors.

Good



Are services effective?

We rated effective as **good** because:

Good



Summary of findings

- Patients had access to physical health checks on admission and throughout their stay.
- Staff provided a range of recovery focused interventions and activities to support patients to move on to more independent accommodation. Care and treatment was delivered in line with national guidance and best practice.
- Staff working in the hospital had the skills and experience to deliver care and treatment to patients. The hospital also had access to a wide range of other professionals to support care.
- There was a long-standing staff group with a high level of expertise.
- All new staff had received a thorough induction to the hospital.
- Staff received regular supervision and appraisal meetings.
- The service held effective handover meetings and demonstrated positive multi-disciplinary working and cross agency working.
- Staff applied the Mental Capacity Act appropriately to the needs of the patients.
- Staff used a mood rating tool which was recorded in the patient record such as the health of the nation outcome score to measure patient outcomes.

However:

- Only 8 out of 23 staff had completed Mental Health Act training although all demonstrated an ability to apply the Act appropriately

Are services caring?

We rated caring as **good** because:

- Feedback from all patients was positive. Patients said that staff responded compassionately to their needs and were skilled in dealing with vulnerable individuals with complex physical and mental health needs.
- Staff were hard working, caring and committed to delivering a good quality service. They spoke with passion about their work and were proud of what they did.
- Staff attitudes and behaviour when interacting with patients showed they were discreet, respectful and responsive. Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes to patients without fear of consequences.
- Staff understood the needs of patients; including their personal, cultural, social and religious needs. Staff kept the confidentiality of information about patients and supported them to make choices about sharing information.

Good



Summary of findings

- Patients were supported to manage their own health and care when they could, and to maintain their independence. The interim service manager was visible so that relatives and patients could speak with them as necessary.
- Patients were included in decision-making and staff listened to their wishes. We saw staff discussing care options and treatments, and provided choice to patients.
- Staff listened to patients and gave them emotional support via regular and impromptu one to one time. Staff overcame communication obstacles. These were overcome compassionately when working with people living with cognitive impairment.
- Patients had access to advocacy services and staff promoted its use.
- Generally, relatives said they felt involved and had the opportunity to speak with medical and nursing staff when needed.
- The service collected patient feedback and used these to make improvements. Patients and carers were involved in and consulted on developments and changes to the day to day running of the service

However:

- One carer told us that it was sometimes difficult to get through to the hospital at night on the telephone.
- Staff had only documented that they gave patients a copy of their care plan in three records.

Are services responsive to people's needs?

We rated responsive as **good** because:

- The hospital catered for the specific dietary requirements of patients.
- There was a strong focus on discharge planning which was reflected in the skill based care plans developed by the staff. Discharge planning was aided by the involvement of team from the local NHS trust who attended care reviews regularly.
- The service had a separate female lounge to the main communal area. The area was sparsely decorated and not personalised to the client group.
- Patients had their own rooms where they could keep personal belongings safely. There were quiet areas for privacy

Good



Summary of findings

- The design, layout, and furnishings of the service supported patients' treatment, privacy and dignity
- Staff supported patients with activities outside the hospital, such as work, education and building family relationships
- The service was accessible to all who needed it and took account of patients' individual needs. Staff helped patients with communication, advocacy and cultural support
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Are services well-led?

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

- The service was well led at service level and by the service provider executives. Executives were visible and accessible to staff and patients. They could discuss the present and future vision for the service.
- There was a commitment to services continual improvement and innovation.
- The service was responsive to feedback from patients, staff and external agencies.
- The service manager and senior staff from the provider had recently recognised that some staff morale was low due to issues with the former manager. The recent changes to the manager of the service seems to have addressed this issue.
- There was clear learning from incidents.
- The service had been proactive in capturing and responding to patients concerns and complaints. There were attempts to involve patients in all aspects of the service.
- Staff had lead roles within the unit and conducted audits.

Good



Summary of findings

Information about the service

Cypress Hospital has recently moved to a new premise which had previously not been inspected by the CQC. The service is a single site which provides “step-down” and short-term crisis admissions for up to 12 men and women over the age of 18 years with mental health needs.

Step-down rehabilitation is for people who are currently in an acute hospital setting who no longer need the support of an acute service. However, they may still require hospital support for short periods of time. The service has a target length of admission of 28 days. Crisis placements are for patients who need a short-term level of hospital support but do not need the facilities of an acute service.

All rooms were single occupancy with ensuite facilities located in single sex corridors

The service has a target length of stay of 28 days

Crisis placements are for patients who need a short-term level of hospital support but do not need the facilities of an acute service.

The service is managed by Community Care Trust (South West) Limited, trading as Step One Charity, which is a registered charity that provides a range of services for people with mental health problems in Torbay and South Devon.

Cypress hospital is registered to carry out:

Accommodation for persons who require nursing or personal care.

Treatment of disease, disorder or injury.

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

There was no registered manager in place at the time of the inspection. The nominated individual and chief executive officer was supporting an interim manager who had applied to CQC to become the registered manager.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, one of whom had experience of this type of service

Why we carried out this inspection

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

How we carried out this inspection

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

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

- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

Summary of findings

- visited Cypress hospital, looked at the quality of the service environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with two carers of people using the service
- spoke with the acting manager and nominated person for the service
- spoke with eight other staff members including doctors, nurses, occupational therapist, a pharmacist and maintenance workers
- received feedback about the service from the deputy chief operating officer from the local mental health trust that commissions the service
- received feedback from two crisis team managers from the local NHS trust who interface with Cypress hospital
- attended and observed one hand-over meeting and one multidisciplinary meeting
- looked at eight care and treatment records of patients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with three patients and two carers who told us that they found the staff helpful and easy to speak to. They described feeling safe and well cared for. They felt that the environment was good although the service was still settling into its new environment

Areas for improvement

Action the provider SHOULD take to improve

- The service should ensure that the plan to mitigate the risk from ligatures is put in place as described in the updated environmental risk assessment following discussions at the inspection
- The service staff should ensure that they complete the plan to mitigate the identified blind spots
- The service staff should ensure that carers are included in care planning meetings
- The service staff should make efforts to ensure that telephones are answered to enable patients to receive calls
- The service staff should ensure that they document that patients were offered a copy of their care plan
- The service should ensure that mental health act paperwork is correctly completed and up to date
- The service manager should ensure that all staff complete Mental Health Act training
- The service team should make efforts to make the environment homelier in response to patient comments
- The service should address the concerns of patients about people smoking outside the lounge causing it to be cold and smell of smoke

Community Care Trust (South West) Limited

Cypress Hospital

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)

Cypress Hospital

Name of CQC registered location

Cypress Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Staff understood their roles and responsibilities under the Mental Health Act 1983 (MHA) and the Mental Health Act (MCA) Code of Practice.

Managers made sure that staff could explain patients' rights to them. We saw evidence of compliance with the mental health act in all but one case.

We saw relevant MHA policies and processes. Oversight is offered via a service level agreement with the local NHS trust.

All patients had been properly informed of their rights and this was recorded in the patient notes.

Section 17 leave could be taken as requested.

Second opinion appointed doctors were attending however in one case we found a wait of eight weeks for this to take place. The service management had escalated it to the MHA. administrator's office to CQC.

Original copies of the MHA papers were stored on the premises with copies being sent to the administrator's office.

We saw posters explaining who the local independent mental health advocates are and how to contact them.

Staff told us that they facilitate section 117 after care meetings on site, although it is the local community mental health team who arrange them.

Only eight of 23 staff had received MHA training with two further staff booked to receive training in November 2018. All of those who had received or were due to receive training were registered nurses therefore a high percentage of the registered nurses were or were due to be trained. The service told us that it was going to commission additional training for all staff soon.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 (MCA) and assessed and recorded capacity.

Eighty seven per cent of staff had completed MCA training.

Staff and managers could describe the principles and application of the Mental Capacity Act.

Staff were confident in how to assess capacity and apply for deprivation of liberty safeguards if necessary.

The service had policies on the MCA.

Staff knew where to access advice on the application of the MCA via the MHA administrator's office within the local NHS provider.

Staff undertook mental capacity assessments when a patient's capacity to make a specific decision was in question. Staff understood that as they worked closely with an individual they were often best placed to make that assessment rather than defer to other professionals. Capacity assessments were recorded in the clinical records.

The manager of the service oversaw deprivation of liberty safeguard applications to the local authority. The manager was knowledgeable in this area. There were no patients subject to DOLS at the time of the inspection.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

Safety of service environment

Cypress hospital had recently moved from its previous premises in Paignton to a new building in Newton Abbott. This addressed many of the concerns we had about environment in our previous inspection. Regular environmental risk assessments were undertaken and the results documented.

Staff were not able to see the bedroom area as these were on the first floor, whilst the staff office and communal areas were on the ground floor. Patients at higher risk could be accommodated in two rooms on the ground floor in rooms which were more visible. Staff carried out hourly checks of all patients and a full program of activities and therapy encouraging people to be present in communal areas during most of the day.

The service had identified several blind spots that staff could not easily observe. Convex mirrors had been installed to help mitigate the risk. We found three further blind spots during the inspection. This was brought to the attention of the manager, who immediately arranged for additional convex mirrors to be put in place.

Staff carried out regular ligature risk assessments, a ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The identified ligature points were monitored by CCTV but staff needed to log onto a computer to view the CCTV feed. There was no specific protocol around frequency of checking CCTV. Staff assessed individuals risks and if they were assessed as at risk of ligaturing then they were placed on a higher level of observation.

During the inspection, we identified five potential ligature points associated with door shutters. Staff had identified the potential risk associated with doors but had not recognised the risk associated with the concealed closers. We brought this to the attention of the manager who put in place a plan to mitigate the risk. The plan ensured staff focussed on increased risk assessment associated with ligatures and ensuring greater staff awareness of the higher

risk areas. In addition, the service planned to install monitors in all staff areas which constantly display CCTV feeds covering the doors. Patients spent most of their time in communal areas. This further mitigated the ligature risk as staff were present in these areas.

Staff carried personal alarms linked to a service wide system. The alarm system was regularly tested to ensure it was in good working order.

Maintenance, Cleanliness and infection control

The service area was clean and well maintained. Records of specific cleaning checks were being maintained for example.

Staff adhered to infection control principles and described and carried out best practice. Posters were displayed prompting staff to carry out infection control practices such as hand washing. We saw staff following hygiene recommendations.

Clinic Room equipment

The clinic room was fully equipped with appropriate equipment. The service had a defibrillator which was regularly checked as part of the weekly clinic room checks.

Safe staffing Nursing Staff

The team had two registered mental health nurses with two support workers working every day shift. One registered nurse worked through the night with an additional support worker. The manager had plans to increase this to three staff. Additionally, the team had an occupational therapist and an assistant working during the week.

The service had enough nursing and who knew the patients and received basic training to keep people safe from avoidable harm. At the time of the inspection, the service has one registered nursing vacancy which was being covered by an agency nurse on a long-term contract.

Rotas did not show any gaps in staffing which may impact on staffing the delivery of care.

At the time of inspection, the service had one health care assistant vacancy which was being covered by bank staff who were regularly used by the service provider therefore maintaining consistency.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

The manager could adjust staffing levels in response to the changing needs of the patients. In turn this was delegated to registered nurses who could increase the staffing compliment without the need to contact more senior staff. This ensured the service always maintained safe staffing levels.

The service had its own bank of staff and used regular agency staff who were known to the service to maintain consistency. All bank and agency staff attended a comprehensive induction programme.

A member of staff was visible at all times in communal areas. The service had recently moved its staff office so that staff were more accessible to patients and could more easily observe communal areas

Patients fed back that they received regular one to one time. This was clear from care plans which reflected those sessions.

Medical staff

The service had a service level agreement with the local mental health NHS trust to provide medical cover. The two consultant psychiatrists for South Devon and Torbay attend the service weekly to undertake clinical reviews of patients and would attend more frequently if required.

Additional medical cover, provided by junior doctors was accessed via the local acute admissions service. Junior doctors attend to see newly admitted patients in a timely manner. On-call arrangements were via the local mental health trusts on call rota. Staff told us that they received a positive service from the local team.

Mandatory training

The service provided mandatory training core clinical skills to all. We reviewed training records which demonstrated mandatory training was being completed by most staff. The service manager could identify those who had not completed their training and had action plans in place to address this through management supervision

Assessing and managing risk to patients and staff

Staff completed and updated risk assessments for each patient and used these to understand and manage risks individually. Staff did not use blanket restrictions

Patients were admitted following contact with the crisis resolution teams or acute in-patient services managed by

the local mental health trusts, these services provided risk assessments. On admission a short risk checklist was completed with staff completed a full risk assessment within the first 48 hours of admission.

We saw evidence of risk assessments being updated to reflect changes in risk. For example,

All patients were checked hourly, with those assessed as being at higher risk placed on more frequent levels of observation.

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. Eighty seven percent of staff had received training in safeguarding.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. The service maintained paper records and we saw clinical information from partner agencies, including the mental health trust, printed and added to the patient records. At the time of the inspection the service did not have access to the computerised patient record used by the mental health trust. However, we were told that read only access to this system was going to be put in place.

Medicines management

Staff followed best practice when storing, dispensing, and recording medication. Staff regularly reviewed the effects of medications including anti-psychotics on each patient's physical health. We saw audits of medicines which were overseen by a pharmacist from the local mental health trust.

The physical health of patients was assessed regularly using the modified early warning score (MEWS). This assisted with the monitoring of adverse effects related to the use of neuroleptic medication

Staff conducted a weekly medicines audit. The audit had picked up that one chart had not been signed but action had not been taken to sign it.

In the clinical room there were folders that contained national institute for health and clinical excellence (NICE)

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

guidelines for medicines and physical health for weight management, asthma, hypertension, sepsis and controlled drugs. Staff were aware of these and told us that they used them

Track record on safety

There had been no serious incidents in the last twelve months

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately using the service..

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. We saw an example of a patient being informed of an issue by staff.

All incidents were reviewed at an organisational level and the learning from the service and other services were fed back to the manager. Team meetings had learning from incidents on the agenda.

Staff told us that they had opportunities to discuss incidents in debriefing sessions and at team meetings following feedback from investigations

Staff had recently received training on using a new form which managers had created to clarify which incidents should be reported. We reviewed one incident which had been more serious than originally reported in response to which the service reviewed it's incident reporting procedure.

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

We reviewed eight care records. All eight had a care plan present but only three had been regularly updated in line with the policy which stated they should be updated on a weekly basis

Staff completed comprehensive mental health assessments of each person which included current risk factors, historical risk, what the person was hoping to achieve, their aspirations for recovery, a moving on plan, where they wanted to live, employment opportunities, hobbies and social connections. The occupational therapist completed falls assessments with people when appropriate.

Staff accompanied people using the service to junior doctors for physical health checks as soon as they were admitted to the hospital. Staff recorded these assessments on specific physical health forms.

Patients completed a physical health questionnaire upon admission and staff monitored their physical health weekly. Staff monitored blood pressure, pulse, temperature, weight, weight change, waist measurements, body mass index and oxygen saturations.

Staff undertook additional monitoring, such as weight gain, for people on anti-psychotic medication. However, staff did not always record why physical health monitoring had not been completed. We raised this with staff and physical health lead who told us that they had not completed the physical health monitoring section because the person was on leave at the time or had refused the check, they agreed to record if this was the case in the future the service uses the modified early warning score (MEWS) to monitor the physical health of patients

Staff met with people before their reviews to prepare and lessen any anxieties about the meeting. This enabled patients to ensure their voice was heard.

All care records were personalised, holistic and recovery-orientated. Staff had documented a 'strengths assessment' in each care record which detailed what the person hoped to achieve and what was important to the person. Care plans were written in the first person and clearly stated

what the person had said. Care plans detailed specific dietary, cultural, physical health and communication support. Three out of the eight care plans had been regularly updated.

Best practice in treatment and care

Staff followed NICE guidelines when offering care and treatment interventions. There was a staff lead who was responsible for updating NICE guidelines and staff could access these in a file held in the therapy room. The manager also emailed updates of NICE guidelines to the staff team.

Staff supported people to live healthier lives as part of their physical health checks. Staff identified if people wanted to access smoking cessation groups, healthy eating groups or sexual health support. Staff had the autonomy to refer people onto the appropriate service. Staff could refer people to the gym and staff had recently started a 'food and mood' awareness group. Staff supported people to access a healthy lifestyles team, which included support to build friendships and reduce isolation and loneliness. Staff provided self management groups where people could access support on sleep issues, anxiety and coping with emotions.

Staff used a mood rating scale to assess the level of people's mood. This was documented in people's care plans and risk assessments. The service did not use any other recognised rating scales to rate severity and to monitor outcomes. The service does not use any rating scales such as health of the nation outcome scores to monitor changes in mental wellbeing.

All staff, including night staff, participated in clinical audits. Each member of staff had a specific responsibility which they audited regularly.

Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff supported patients with their physical health and encouraged them to live healthier lives.

Skilled staff to deliver care

Medical and pharmacy input was provided at the hospital by staff from the local mental health trust. A service level agreement was in place.

People on the service continued to access psychological intervention through their local community mental health team

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Managers ensured staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision, opportunities to update and further develop their skills. The occupational therapist had been supported to undertake a master's degree whilst employed by the service.

Staff could attend specialised training by requesting funding, although no staff are currently doing this.

Poor performance was identified by the manager and a process was in place to manage those staff who had performance issues.

All staff had regular supervision and appraisals. Staff also had professional specific supervision as part of their HCP registration.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients via multi-disciplinary meetings and handover meetings.

There were close working relationships between nurses, occupational therapist and health care support workers employed by the service. They delivered a full schedule of care and therapeutic activity throughout the week.

We spoke with members of staff from the local mental health trust who work with Cypress hospital. They reported very close working relationships and we saw staff including support workers, consultant psychiatrists and a pharmacist working in the service alongside directly employed staff.

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

Staff recorded when they had explained people's their rights under the Mental Health Act to them. Patients were also given information about section 17 leave, section 132 (may be worth explaining) and medicines.

Of the three records of people who had been detained under the MHA that we reviewed, all three had the relevant documentation present. Staff kept original section papers in separate MHA files in the locked cupboard in an office. Leave forms were present in all records viewed. Staff discussed people's options for leave in their weekly reviews and asked for their preferences.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. We saw relevant mental health act policies and

processes. Oversight is offered via a service level agreement with the local NHS trust. Original copies of the Mental Health Act papers were stored on the premises with copies being sent to the administrator's office.

Section 17 leave could be taken as requested.

Second opinion doctors were attending, however in one case we found a wait of eight weeks for this to take place. The service management had escalated it to the mental health act administrator's office.

We saw posters explaining who the local independent mental health advocates are and how to contact them.

Staff told us that they facilitate section 117 after care meetings on site, although it is the local community mental health team who arrange them.

Only eight of 23 staff had received mental health act training with two further staff booked to receive training in November 2018.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the Mental Capacity Act 2005 and assessed and recorded capacity clearly.

MCA training had been completed by 87% of staff

Staff and management could describe the principles and application of the Mental Capacity Act.

Staff were confident in how to assess capacity and apply for deprivation of liberty safeguards if necessary

The service had policies on the mental capacity act

Staff knew where to access advice on the application of the mental capacity act via the mental health act administrator's office.

Staff undertook mental capacity assessments when they deemed capacity to be in question. They understood that as the clinicians who are working most closely with an individual they are often best placed to make that assessment rather than defer to other professionals. Capacity assessments were recorded in the clinical record

The manager of the service oversees deprivation of liberty safeguard applications to the local authority. She could talk in detail about the law and how it interfaced with the Mental Health Act.

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We found that all eight records we reviewed had detailed consent to share information with relatives and/or friends. Staff had also documented the person's consent to an informal admission.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

Staff demonstrated a clear attitude of respectful, compassionate care. We saw them interact with patients in a way that showed they were dedicated to protecting patients' dignity as well as keeping them safe. The three patients we spoke with praised the staff highly, saying that they cared for them and wanted what was best for the patient.

Through assessing patients appropriately, and working with them collaboratively, staff knew how to meet their patients' needs and they ensured that patients had access to other teams when they needed it.

We witnessed discussions in handovers and multi-disciplinary meetings about how best to engage people who were not readily taking up offers of activities.

Staff used language which reflected a respectful non-stigmatising attitude to services people with mental health problems, reflecting that patients were seen holistically.

Patients could have open discussions about their personal, cultural, social and religious needs with staff, as they knew staff would respect their wishes and help meet their needs.

Staff were keen to promote a culture of respect and assured patients that they were safe to raise any allegations of discriminatory behaviour.

Patients told us that they felt the staff were respectful and behaved appropriately to services them

We raised a concern with the manager of the service about the sound proofing between the meeting room and an adjoining room where patients meet with family members. They assured us that they would prevent the family room from being used when the meeting room was also in use.

Staff began an assessment by completing a 'strengths assessment' with the person admitted to the hospital. This looked at the person's goals and what they wanted to work on. Staff created a work plan and reviewed it with the person weekly to check what they were happy or unhappy about. This showed the high level of patient's involvement in their own care.

During coffee mornings, staff informed people using the service who their named nurse was for the day and gave people information about the weekly in house and community activities.

Staff offered activities to people using the service seven days a week. All records that we reviewed had a copy of the person's weekly planner in their support and safety plan.

People using the service said they thought staff respected their family members. Families said that the service had matched a staff member to their relative so they had things in common and the staff member was able to understand the individual needs of their relative. Families were praiseworthy of the staff member supporting their relative.

The involvement of people in the care that they receive

Throughout the admission process staff helped patients settle into the service. Cypress had a detailed welcome pack and assigned staff to be key workers with patients on the service.

We saw that patients had played a key role in developing their care plans, and in creating their personalised activity programs and we saw that wherever possible, the patient was at the centre of the decisions about their care.

People using the service said they had received a copy of their care plan. However, when we reviewed care records, staff had only documented this in three records. Staff documented if people had declined a copy of their care plan.

Staff were skilled at using a range of communication tools to help patients communicate their wishes. Staff used these tools to help patients be involved in their care, and to give them information about their care in a way they could understand. We were told of an example when a sign language interpreter having been used to ensure communication was upheld with patients who were deaf.

Patients were involved in decisions about the services they used. Patients and carers had been included in discussions about the service developments.

The service had a feedback box in the communal area which staff and people using the service used to discuss at their weekly community forum meetings. Staff had created a 'you said, we did' board, displayed in the communal area which reflected the comments made during these meetings. During these meetings, people discussed how

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

they wanted to shape the week ahead and how they wanted to spend their one to one time. Staff recorded feedback on an 'actions' template which was emailed out to the entire team. Staff reviewed actions monthly. During reviews, people using the service also had access to a 72 hour feedback form which included five questions and was repeated two weeks later to see if their feedback had been responded to.

Advocates visited the hospital weekly. They talked to people and checked if they wanted a referral to an advocate.

Carers felt their relatives were receiving high quality care from a staff team that was dedicated to helping them.

Staff routinely collected feedback from patients in a way they could understand. This could include using easy read surveys, and other communication tools. This feedback was collated, and formed the basis of an action plan for staff to discuss anything that arose from it.

Involvement of families and carers

Two out of two carers we spoke with felt that it was at times difficult to get through on the telephone to speak with patients or staff.

One carer we spoke with felt that communication around involvement in care reviews was not always good and they could have been more involved.

Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice. Staff could control admissions from the community and transfers from local hospital services therefore ensuring that they happened at a time that best suited the patient

The staff at the service and partner agencies told us that delayed discharges tended to be related to situations outside of the services control. For example, a lack of appropriate placements for people to move on to in the community.

The facilities promote recovery, comfort, dignity and confidentiality

A decorative 'recovery tree' made by people using service was displayed in the reception area the, patients added leaves with quotes about how the service had helped them with their recovery.

The team displayed activity boards in the communal area which displayed in house and community activities for the upcoming week. Staff informed people using the service about these activities during their morning coffee group.

At the weekends, staff offered a group day trip. This was popular but oversubscribed as the hospital only had one small car. We raised this with the manager at the time of inspection who said they were considering buying a larger vehicle. Staff also offered arrange other activities such as arts groups

The service had an outside smoking area. However, patients smoked just outside the back door to the lounge in a no-smoking area. They left the door open so other patients were subject to the smell of smoke and the cold air coming into the lounge. Patients complained that they did not like the smoke and the cold. The service manager told us that they were becoming a fully smoke free site.

The service had a separate female lounge to the main communal area. The area was sparsely decorated and not personalised to the client group.

The service had a separate occupational therapy area which had cooking facilities and an art area. Staff had risk assessed the area and explained the safe working

procedures to people using the service when they started their session. Damp had infiltrated the back wall which had caused the internal paint to peel off. The manager was aware of this and had plans to redecorate the area.

Staff provided activities for people using the service which included ceramics, art, cooking and life skills.

The unit had good facilities, with clinic rooms and interview rooms available for staff and patients.

Patients had access to their mobile phones and could make calls from their bedrooms.

The service has outside space in which patients can freely spend time. There was ample seating for people to use and the garden was well tended.

People using the service had access to hot and cold drinks and food whenever they wanted. The service had a water dispenser in the communal area. People using the service could write their food requests on a communal white board. People using the service said they liked the food because it was freshly cooked and they could request their favourite meals such as roast dinners. Families of people using the service said the food staff provided had encouraged their relative to eat more.

The service provided a specific room in which patients and their families could meet. This was accessible through a separate entrance meaning that people did not have to walk through the main communal areas.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships. The service parent company is a provider of community based support services and as such links to local community services are strong.

Meeting the needs of all people who use the service

The service was accessible to all who needed it and took account of patients' individual needs. Staff helped patients with communication, advocacy and cultural support. We were told about the services use of interpreters including sign language interpreter.

Patients with specific dietary needs told us that the service considered their needs. We saw that staff had taken steps to help a patient to stay engaged with their local religious community

Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. We saw evidence of complaints being discussed at a wider service level and then being fed back via team meetings.

Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

There was a strong recovery model focus within the service with the aim of aiding people to maintain their independence. We were told that as an organisation the provider is currently developing a new strategy and vision with a greater emphasis on prevention.

Staff told us that they felt able to contribute to the discussion regarding the vision of the organisation.

Good governance

The service had a clear process which identified what should be discussed at a team and service level. The manager and chief executive could fully explain the process for feeding information up and down within the organisation.

We saw evidence of learning from incidents such as the review of absent without leave prevention.

The service is a high reporter of incidents to outside agencies such as the CQC which shows an open positive attitude to services learning

Leadership, morale and staff engagement

The service managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff and patients told us that there was a strong positive culture which has been enhanced by the recent management changes within the service.

Staff told us that they felt able to raise concerns and were confident that the service manager and the wider organisation would be responsive to this.

Staff were aware of the whistle blowing policy and felt confident to use it.

Staff had received or had been booked in to receive an annual appraisal which included a discussion of the future.

Staff sickness rates are not unusually high.

Staff had lead roles within the service, such as physical health and mental health act. Although the audits were longstanding the practice of delegating to leads among the staff group was new and yet to be fully established

The chief executive of the service provider was visible, and based themselves in the service one day a week.

Commitment to quality improvement and innovation

The service showed evidence of improvements however they do not use a recognised model for the identification and implementation of improvement projects. This potentially impacted on the effectiveness of any improvement projects as charting the progress of the project may be difficult without data analysis.

Staff felt able to contribute to discussions about how to improve services and had lead roles within the service.

The service did not participate in any national accreditation schemes or national audits.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

We saw evidence of performance issues being managed well.

The organisational response to the identification of environmental risks was swift and positive.

Staff did not raise concerns which were not already on the risk register.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure systems with security safeguards.

Patient confidentiality was maintained through the appropriate management of information.

Engagement

Patients and carers had the opportunity to provide feedback via many sources including face to face, telephone contact and a feedback box.

Feedback was discussed at corporate meetings looking at the whole organisation and at team meetings to ensure learning.

Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

The friends and family test was extremely positive with 97% of people stating that they would recommend the service to friends or family.

The chief executive of the service provider was on site regularly, staff felt able to approach her with issues if they so wished.

External professionals said that recovery rates and satisfaction rates were higher than most acute services they worked with.