Cygnet Appletree

Quality Report

Frederick Street North,
Meadowfield,
Durham,
DH7 8NT
Tel: 01913782747
Website: http://www.cygnethealth.co.uk

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

Ratings

Overall rating for this location	Not sufficient evidence to rate
Are services safe?	Not sufficient evidence to rate
Are services effective?	Not sufficient evidence to rate
Are services caring?	Not sufficient evidence to rate
Are services responsive?	Not sufficient evidence to rate
Are services well-led?	Not sufficient evidence to rate

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

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

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

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

Summary of findings

Overall summary

We carried out a comprehensive inspection of Cygnet Appletree on 8th and 9th May 2018. At that time, we identified concerns with the safety of the hospital. In June 2018, we received three whistle-blowing's from staff raising serious concerns about the safety of patients and staff, staffing levels and staff training, the attitudes and behaviours of staff at all levels, and the management of the service. The whistle-blowers also stated that staff had felt unable to speak truthfully at the time of the comprehensive inspection, therefore we could not trust all of the evidence gathered at that time. We returned on 27th and 28th June 2018 to look at these specific concerns. As this was a focused inspection, we have insufficient evidence to rate this hospital. However, due to the seriousness of the issues found at this inspection, we have taken action against this provider in line with our enforcement powers.

- The service was not safe. Patients did not feel safe due to the high numbers of incidents of violence and aggression. Staff and patients were experiencing aggressive behaviours on a regular basis. The service did not have enough staff to provide safe care and treatment.
- The service was not effective. Staff did not provide care that met the needs of one patient with a learning disability and did not have the required skills and knowledge to support this patient group. Staff were not monitoring the effects of high dose anti-psychotic medication on one patient's physical health.
- The service was not responsive. Staff were not meeting the needs of all patients being admitted to a rehabilitation environment. Staff did not manage complaints in line with the provider's policies or support patients to raise concerns.
- The service was not well-led. Systems that were in place to ensure good governance of the service were not being operated effectively. Managers did not notify CQC of all incidents as required. Staff raised concerns about poor leadership, a bullying culture and low staff morale. There was a lack of visible clinical leadership and effective team working.
- Staff were not always caring. Staff did not always treat patients with dignity and respect. Staff and patients raised concerns about the attitudes and behaviours of staff towards patients.

Summary of findings

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Not sufficient evidence to rate

Cygnet Appletree

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Summary of this inspection

Background to Cygnet Appletree

Cygnet Appletree's statement of purpose states that the service provides specialist mental health rehabilitation to women aged 18 and above in a safe and comfortable environment. Cygnet classifies this rehabilitation ward as complex care. It provides services to up to 26 patients who are detained under the Mental Health Act 1983 or admitted as informal patients. It is situated in its own grounds in Meadowfield, close to the city of Durham.

The hospital has 26 en-suite bedrooms and the provider's statement of purpose says that they provide the following;

- specialist treatment programmes for forensic patients, including self-harm, addictions, personality disorder, anger management
- daily living skills and vocational development

At the time of inspection, the hospital had 21 patients, three of whom had a diagnosed learning disability.

The hospital had a registered manager and a controlled drugs accountable officer at the time of the inspection. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations. Controlled drugs accountable officers are responsible for all aspects of controlled drugs management within their organisation.

Cygnet Appletree has been registered with the CQC since 26 September 2012. Appletree has previously been managed by two other providers. In March 2018, the provider of Appletree became Cygnet Behavioural Health Limited and the hospital was re-named Cygnet Appletree. It is registered to carry out two regulated activities; assessment or medical treatment for persons detained under the Mental Health Act 1983, and treatment of disease, disorder, or injury.

Cygnet Appletree has been inspected by the CQC five times since it was registered in 2012. At our last inspection, we carried out a comprehensive inspection of Cygnet Appletree on the 8 and 9 May 2018. We found that Cygnet Appletree was not meeting all the Health and Social Care Act (Regulated Activities) Regulations 2014 relating to the safe key question and we issued the provider with two requirement notices for this service. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 HSCA (RA) Regulations 2014 Safe Care and Treatment because of inaccuracies in medication stock records.
- Regulation 18 HSCA (RA) Regulations Staffing because staff training in life saving did not meet with the requirements of the UK Resuscitation Council.

Our inspection team

The team that inspected the service comprised three CQC inspectors.

Why we carried out this inspection

We carried out a comprehensive inspection of Cygnet Appletree on 8th and 9th May 2018. At that time, we identified concerns with the safety of the hospital. In June 2018, we received three whistle-blowing's raising serious concerns about the safety of patients and staff, staffing levels and staff training, the attitudes and behaviours of staff at all levels, and the management of the service. The whistle-blowers also stated that staff had felt unable to speak truthfully at the time of the comprehensive inspection, therefore we could not trust all of the evidence gathered at that time.

We returned on 27th and 28th June 2018 to look at these specific concerns. As we cannot be assured that the

Summary of this inspection

evidence gathered at the comprehensive inspection was accurate, and we have looked only at specific areas in this inspection, we have insufficient evidence to rate this hospital. However, due to the seriousness of the issues found, we have taken enforcement action against this provider.

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?

As this was a focused inspection, we only reviewed certain parts of each of these areas in order to focus on the specific concerns raised.

During our inspection we:

- toured the ward environment and observed how staff were caring for patients
- reviewed five patient records and 96 incident reports
- interviewed nine patients
- interviewed the head of care for the service
- interviewed 11 current staff and received feedback from four previous staff members including medical staff, nurses and healthcare assistants
- reviewed a range of other documents, policies and procedures relating to the running of the service including information from external stakeholders.

What people who use the service say

We spoke with nine patients who used the service. Patients did not feel safe at Cygnet Appletree as a result of the high numbers of incidents of violence and aggression from other patients. Patients gave negative feedback about the attitudes and behaviours of staff towards them.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Not sufficient evidence to rate

This was a focused inspection in relation to concerns raised about Appletree. We did not have sufficient evidence to rate this key question, however we have taken action against this provider in line with our enforcement powers.

- Patients did not feel safe on the ward. There were high numbers of incidents of self-harm, violence and aggression.
- Staffing establishment levels did not meet with national guidance. Staff and patients reported that staffing levels were not sufficient to provide safe care and treatment. The provider was not always meeting their own staffing establishment levels.
- Staff were not adhering to the provider's staffing policy when patients required levels of increased observations.
- Staff turnover was high due to the number of staff leaving and there had been a lack of consistency in medical cover. This meant medical staff were not always able to respond to an emergency within 30 minutes.
- The majority of self-harm incidents were classified as low level with no lessons learned identified.
- We were not satisfied that staff responded appropriately to serious safeguarding concerns.
- Staff placed restrictions on patients that were not based on an individual assessment of risk and need or formally documented and reviewed.

Are services effective?

Not sufficient evidence to rate

This was a focused inspection in relation to concerns raised about Appletree. We did not have sufficient evidence to rate this key question, however we have taken action against this provider in line with our enforcement powers.

- Staff were not delivering care and treatment in line with evidence based guidance for one patient with a learning disability.
- Staff were not trained in how to deliver appropriate care to patients with learning disabilities and some felt they lacked the knowledge and skills to effectively support patients with a learning disability.
- Staff did not always ensure the physical health of one patient receiving high-dose antipsychotic medication was monitored.
- Staff were not effectively managing the physical health of one patient with diabetes and took the incorrect action in response to blood glucose levels being high.

Summary of this inspection

Are services caring?

Not sufficient evidence to rate

This was a focused inspection in relation to concerns raised about Appletree. We did not have sufficient evidence to rate this key question, however we have taken action against this provider in line with our enforcement powers.

- Staff did not always treat patients in a respectful and dignified manner. Some staff and patients raised concerns about the attitude of staff towards patients and the behaviour of staff around patients.
- Staff had written incident reports with a disrespectful tone towards the patients involved.
- Staff did not fully support patients to raise concerns about their care and treatment and had a dismissive attitude towards patients who complained.

Are services responsive?

Not sufficient evidence to rate

This was a focused inspection in relation to concerns raised about Appletree. We did not have sufficient evidence to rate this key question, however we have taken action against this provider in line with our enforcement powers.

- The provider was admitting patients that were not suitable for a rehabilitation environment and not in line with their statement of purpose.
- Managers did not accurately monitor all complaints from patients or respond to them in line with the provider's policy.

Are services well-led?

Not sufficient evidence to rate

This was a focused inspection in relation to concerns raised about Appletree. We did not have sufficient evidence to rate this key question, however we have taken action against this provider in line with our enforcement powers.

- Systems that were in place to ensure good governance of the hospital were not being operated effectively.
- Managers did not report all incidents to the CQC as required by the Health and Social Care Act Registration Regulations (2009).
- Staff raised concerns about poor leadership, a culture of bullying and low morale.
- Staff reported they had previously been afraid to raise these concerns due to fear of repercussions.
- There was a lack of clinical leadership for support staff and a lack of cohesive team working between nursing and support staff.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We did not review Cygnet Appletree's compliance with the Mental Health Act during this focused inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review Cygnet Appletree's compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards during this focused inspection.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Long stay/rehabilitation mental health wards for working age adults

Not sufficient evidence to rate

Safe	Not sufficient evidence to rate
Effective	Not sufficient evidence to rate
Caring	Not sufficient evidence to rate
Responsive	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate

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

Not sufficient evidence to rate

Safe and clean environment

Cygnet Appletree was clean and well maintained. The environment was regularly cleaned, furnishings and fittings were in good order and the décor was maintained to a high standard.

The door to the occupational therapy kitchen was missing a handle. The head of care was not aware of this although we saw it had been discussed in the morning meeting. This meant if closed, those inside could not open the door to get out. We raised this and the hospital told us that a new handle was fitted following our inspection.

Safe staffing

Staffing levels were not sufficient to meet the needs of the patients. There was not an adequate number of staff in place on all shifts to manage the frequency of incidents, the complex needs of patient and to ensure rehabilitation activity could be delivered in a safe environment.

Cygnet's staffing establishment levels did not meet with current guidance set out by the Royal College of Psychiatrists AIMS Rehab and quality network for mental health rehabilitation services. Cygnet Appletree classified itself as a complex care unit. The AIMS Rehab accreditation scheme guidance states that a complex care unit that admits detained patients provides at least one qualified nurse and one unqualified member of staff on shift at all times per 14 patient beds.

Cygnet used their own safe staffing tools to establish the number of staff required on each shift. The hospital had 21 patients at the time of inspection, two of which were informal. Cygnet's recommended optimum staffing levels were therefore nine staff on each day with two qualified nurses, and seven staff on at night with one qualified nurse. Cygnet also identified a minimum safe staffing level of one qualified and four unqualified at all times, dependent on severity of individual risk. This was less than the staffing recommended by national guidance.

Staffing at the hospital did not always meet with the provider's own required staffing establishment levels. We reviewed rotas between 1 May 2018 and 25 June 2018. We found on eight out of 42 shifts there was only one qualified staff member on a day shift. The head of care told us they tried to staff with two qualified nurses on a night shift where they could. There was only one qualified staff member on all except one of the 42 night shifts. Following the inspection, the provider submitted information about staffing levels for a different time period. They stated that on 48 shifts between 1st May 2018 and 17th June 2018, all day and night shifts complied with safe staffing levels. This information did not differentiate between qualified and unqualified staff. This information also showed that the provider did not meet their optimum staffing levels on 12 day shifts and 35 night shifts.

Although the head of care was usually on-site Monday to Friday, they were in addition to the rota and had a management role to undertake. On the day of inspection,

there was only one qualified nurse on shift and a new patient was being admitted. Support staff were observed trying to locate the qualified nurse to assist with the admission of the new patient.

Staff were not managing increased levels of observation in line with the provider's policy. There was one patient on constant one to one observations at the time of inspection, which was being absorbed within the current staffing levels. The policy stated that for up to two patients on one to one observations, the staffing levels should be one qualified nurse and two unqualified staff. Managers had told us that two patients on increased observations were absorbed within the current staffing levels. The provider intended to review the policy and interpretation of it following the inspection.

Patients did not raise concerns about the use of bank staff. The hospital used regular bank staff that were familiar with the environment and the patients. Of the 42 day shifts reviewed on inspection, 33 used unqualified bank staff and five used qualified bank staff. Of the night shifts, 11 used unqualified bank staff and none used qualified bank staff.

Nine staff reported that staffing levels were not always safe or sufficient. They felt this impacted on one to one time with patients and stated that if there was more than one incident at any one time they may struggle to safely manage it. Managers informed us that Cygnet Appletree had a multi-disciplinary team on site during the day that could be called upon to respond in an emergency. All staff were trained in managing actual and potential aggression and included psychologists, occupational therapists, maintenance, kitchen and housekeeping staff. These staff were not available during the night. Cygnet Appletree was a stand-alone unit and could not call on assistance from other units during an emergency.

Seven patients reported that clinical staff were rarely visible on the ward unless they were administering medication. All seven patients had a named nurse however they reported they rarely had one to one time with their named nurse. Managers did not monitor this specifically, but as part of the patients' engagement in meaningful activity. Three patients reported they could not always get leave as requested or had to wait all day for it, which they felt was due to staffing levels. Managers did not monitor if leave was cancelled or re-arranged.

There had been a lack of consistency in doctors at the hospital. Cygnet Appletree had employed four responsible clinicians over the previous two years with the use of locum staff in between where there were gaps in employment. The hospital had no responsible clinician from 11 May to 23 May 2018, with cover provided by responsible clinicians from other Cygnet hospitals during that time. A locum psychiatrist was then in post for four weeks and a permanent consultant psychiatrist had commenced the day before inspection. Staff also previously had access to a part time speciality doctor, but this post had not been filled since August 2017 with no plans to recruit at the time of inspection. Staffing guidance as quoted previously recommended one 0.5 psychiatrist and one whole time equivalent core trainee or equivalent or every 14 patients.

None of the responsible clinicians were available within 30 minutes of the hospital during the period 11 May to 23 May 2018. This was also the case for the on-call rota on a weekend. Medical cover was provided on a rota basis for the responsible clinicians of four Cygnet hospitals in the area. The hospitals were not located within thirty minutes of each other, therefore a doctor was not available within 30 minutes of Cygnet Appletree at all times. National Institute for Health and Care Excellence Violence and Aggression: short term management in mental health, health and community settings (NG10) states that staff trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend an emergency if restrictive interventions might be used. Accredited for Inpatient Mental Health Services Standards for Inpatient Mental Health Rehabilitation Services also states that the doctor needs to be able to attend the ward/unit within 30 minutes in the event of a psychiatric emergency.

Staff reported turnover was high and data provided at the time of inspection showed the annual turnover rate for the previous twelve months was 49%. Staff gave examples of new starters who attended for their first day of induction and didn't return. There had been 17 staff leavers between 25 January 2018 and 22 June 2018. Amongst the reasons given for leaving, seven had resigned, three had stated the job was not for them and three had a new job elsewhere.

Long stay/rehabilitation mental health wards for working age adults

Not sufficient evidence to rate

At the time of inspection, the vacancy rate was 13%. Two new administrators and the responsible clinician had commenced employment the day before inspection and the nurse vacancy had been filled with a start date of September 2018.

Assessing and managing risk to patients and staff

The service was not managing the risks presented by patients to other patients and staff. We took action about this following the inspection. Seven of the nine patients we spoke with did not feel safe on the ward and all patients we spoke with had witnessed or been involved in frequent incidents of violence and aggression. Comments included that this is "not rehab, full of violent people" "I don't feel safe" and "it's really violent, I got attacked Sunday, Monday and Tuesday, I don't feel safe". One patient spoke of an incident where they had refused to return to the ward as they had been assaulted by another patient prior to their escorted leave and didn't feel safe. They stated staff told them they had to return or they would lose their access to Section 17 leave.

All of the staff spoken to reported high numbers of incidents and 11 staff felt that the hospital admitted patients who were not suitable for a rehabilitation environment due to the risks they posed. The incidents involved high numbers of self-harm and assaults on patients and staff. One staff member stated, "we are being assaulted and nothing is being done and there is no support" and another said, "we have almost got used to the shift in attitude where it is standard for a support worker to be assaulted".

We reviewed 96 incidents that had occurred in a 56-day period between 1 May 2018 and 25 June 2018. Of these, 43 involved restraints on patients and seven of those restraints involved rapid tranquilisation. We reviewed an incident where restraint was used to administer a depot injection to a patient who was acutely unwell. The incident report (IR1) stated that the patient had refused their depot medication and that a response team was used to administer the depot using restraint. There was no evidence in the incident report (IR1) that staff had used alternative strategies or de-escalation techniques to encourage the patient to accept their medication. Staff completed a second form, titled 'MAPA incident report' and had ticked three boxes indicating they had attempted three de-escalation strategies. The incident report (IR1) noted that a response team was used to restrain the patient to administer medication within twenty minutes of the patient's first refusal to accept medication.

Staff were trained in managing actual and potential aggression, although one staff member reported they had been expected to go onto the ward prior to having this training and that this felt unsafe. We also received feedback from one external agency that they had been left alone on the ward with a patient who posed a risk to staff and patients, without having the support of staff or required training. Staff understood de-escalation and stated that restraint was a last resort, but that it happened frequently due to the risks posed by some of the patients and the number of incidents.

Staff completed risk assessments of patients using validated tools and reviewed patient risk daily. The hospital used the short-term assessment of risk and treatability tool. This was an evidence-based tool that assessed future violent and risk behaviours in the short term and identified risk to self and others through structured professional judgements. Repeat assessments captured attitudes and behaviours over time to evaluate patient progress. Following this, staff completed the historical clinical risk management (20) which is a tool used to assess the risk for future violent behaviour. This type of risk assessment is mainly used with patients with a forensic background and the hospital should consider whether there are more suitable assessment tools for use in a rehabilitation environment.

Staff held a weekly reducing restrictive practice meeting and each patient had a reducing restrictive practice care plan in place. However, patients reported that the kitchen and lounge area was locked during the night and we saw this documented in an incident report. The managers confirmed this was locked from midnight on weekdays and 1am on weekends to promote good sleep hygiene. They intended to discuss this with patients to review access following the inspection and add it to their restrictions review meeting.

Staff had raised seven safeguarding alerts between 1 May 2018 and 25 June 2018. All of these were a result of patients being assaulted by other patients. We raised a safeguarding concern during our inspection with the manager. We were

Long stay/rehabilitation mental health wards for working age adults

Not sufficient evidence to rate

not satisfied that the initial response to this concern ensured that patients were protected from further harm. We raised this again and further necessary action was taken by staff to safeguard the patients.

Track record on safety

There had only been one reported serious incident in the 12 months prior to inspection. This involved the death of a patient and the investigation was ongoing at the time of inspection.

Reporting incidents and learning from when things go wrong

Staff did not always review and learn from incidents to ensure they took necessary action to avoid them being repeated. The provider's serious incident policy did not guide staff in how to assign a level of seriousness to incidents of self-harm. Between 25 June 2017 and 25 June 2018, the hospital recorded 406 incidents of self-harm. Of these incidents, 375 were classified as low level self-harm by staff which did not require medical assistance or required assistance such as basic first aid which would have been completed by nursing staff or the patient. Managers told us they based their decision on the level of self-harm, the skill set of staff and what was deemed 'not out of the ordinary' for that patient. Examples given by managers of self-harm classified as low level were a patient banging their head against wall, using an item such as a sock or torn clothing as a ligature around their neck, cutting, punching walls or themselves, inserting an item into a wound, and minor burns such as cigarette burns.

The incident reporting form had a section to identify lessons learned from these incidents and incidents were discussed in the morning meeting. A review of the incident forms and morning meeting minutes showed there was little documented review of these incidents or identification of lessons learned. An example of this is an incident of ligature on 7 June 2018. There was no documented action taken following this incident on the incident form. The same patient again ligatured on 11 June 2018 following which staff increased their observation levels. The remaining 31 of the 406 incidents were classified as moderate to high self-harm which required further medical assistance. Only those incidents classified as moderate to high self-harm were formally reviewed and shared with commissioners and clinical commissioning groups. For the high numbers of incidents classified as low level self-harm, there was a lack of review which did not enable the staff to learn lessons and avoid repeat incidents in the future.

Under Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009, Cygnet Appletree is required to notify the CQC of an incident specified within this regulation which occurs whilst they are carrying out their regulated activity. We reviewed incidents from 1 May 2018 to 25 June 2018 and found 13 occasions where the hospital had failed to notify us of such an incident. Ten involved a patient on patient assault, two involved a patient absent without leave and one was a serious incident, all of which resulted in Police being called. We took action about this following the inspection.

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

(for example, treatment is effective)

Not sufficient evidence to rate

Assessment of needs and planning of care

We reviewed the records of five patients with specific needs to asses whether care was being delivered in line with best practice. Records contained an assessment and plan of care of patients' personal, social, mental health, physical health and rehabilitation needs.

Best practice in treatment and care

In one record reviewed, staff were not delivering care and treatment in line with evidence based guidance for patients with a learning disability. At the time of inspection, the service had admitted three patients with a diagnosis of a learning disability or autism spectrum disorder. We reviewed one care record for a patient who had a learning disability. The patient did not have a health action plan and staff were not using a model of care suitable for this patient, such as positive behavioural support plans. There was no mention throughout this patient's care record of their learning disability or communication needs and how

Long stay/rehabilitation mental health wards for working age adults

Not sufficient evidence to rate

this might impact on their treatment, behaviour and understanding of their plan for care and treatment and their discharge goals. We took action about this following the inspection.

We also reviewed the record of a patient with diabetes. There was a lack of clear and specific care planning to inform staff how to manage this patient's diabetes. We saw evidence of where staff had taken the wrong action in response to a patient's blood glucose monitoring levels and had not followed the basic guidance set out in the patient's care plan.

In one record reviewed, staff did not always complete the required physical health monitoring of patients receiving high dose anti-psychotic medication, in line with national guidance and the provider's policy. We reviewed one patient recorded where the patient had refused physical health monitoring for a period of ten weeks. The patient had been receiving high doses of anti-psychotic medication for a four week period during this time and regular 'when required medicines' to help with extreme episodes of agitation. Staff had continued to administer this medication despite the lack of physical health monitoring of the patient. The record did not evidence how or when staff attempted to encourage this patient to comply with the necessary monitoring. We raised this as a concern during our inspection. Following this, staff reviewed the plan of care to ensure visual physical observations were documented four times per day and the patient agreed to an electrocardiogram and an appointment with their GP. Following a review of the patient's physical and mental state the week after inspection, staff stopped prescribing the high dose antipsychotic medication. We took action about this following the inspection.

Feedback from one external medical professional was that the anti-psychotic treatment prescribed for a patient was inappropriate due to the absence of psychosis and this medication had subsequently been stopped.

Skilled staff to deliver care

Staff were not skilled to meet the care and treatment needs of all patients admitted to Cygnet Appletree. Managers reported that staff had received basic training in learning disabilities and autism from the psychologist and occupational therapist. We reviewed this training during the inspection and found it had not been adequate in ensuring staff had the required knowledge to support patients with a learning disability. Eight staff had not received this training and did not have the required knowledge and skills to support a patient with a learning disability. Three staff we spoke with were not aware of models of care and tools used to support patients with a learning disability when asked about this. We took action about this following the inspection.

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

Not sufficient evidence to rate

Kindness, dignity, respect and support

Prior to, and during the inspection, we had concerns that staff did not always treat patients in a respectful and dignified manner.

We spoke with one member of staff who had a dismissive attitude about patients. One staff member reported that other staff spoke negatively about patients and their families in the morning meeting. Another staff member had raised concerns that staff were giving negative opinions on patients in handovers and one other stated there was a culture of name calling and bad language used by staff and patients. Three patients reported that some staff had a negative attitude towards them, would swear around them and would mock other patients in front of them. Comments included that "if you self-harm they make comments like that's ridiculous" and "staff take the mick out of her (a patient)".

In three of the 96 incident reports, staff had written them with a disrespectful tone towards the patients involved. The reports gave examples of staff placing restrictions on patients in immediate response to patients' behaviour, which some patients viewed as a punishment.

Staff attitudes did not fully support patients to raise concerns. An example of this was a patient who had been told 'how are we supposed to support you if we don't know' in response to the patient raising concerns with the CQC as opposed to the hospital staff.

Long stay/rehabilitation mental health wards for working age adults

Not sufficient evidence to rate

Patients stated some staff were kind and caring towards them but that this varied depending on which staff were on shift. We observed staff during the inspection behaving respectfully towards patients.

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

Not sufficient evidence to rate

Access and Discharge

Cygnet Appletree's statement of purpose states that they provide specialist mental health rehabilitation to women aged 18 and above in a safe and comfortable environment. Staff had concerns about the appropriateness of some patients for a rehabilitation unit and we observed patients during the inspection whose presentation was acutely psychotic. We took action about this following the inspection.

An entry in the notes of one patient described the patient as acutely psychotic and posing risks to staff in a targeted manner. Records stated the team was in agreement that the patient was not stable enough to engage in rehabilitation and was awaiting a period of stabilisation before commencing a rehabilitation pathway. This was eight weeks after the patient had been admitted for rehabilitation.

Patients were being admitted to this rehabilitation unit from psychiatric intensive care units. A psychiatric intensive care unit provides care and treatment to patients who are experiencing the most acute phase of their mental illness. In one such case, a patient had been admitted from a psychiatric intensive care unit over six months ago. This patient was residing in an area that could be easily observed by staff due to the risks they still posed to others. Staff gave examples of how the impulsive behaviour of this patient had resulted in others being assaulted.

Listening to and learning from concerns and complaints

The service did not accurately monitor all complaints from patients or respond to them in line with the provider's policy. The provider's policy stated that 'a complaint is a written or oral/verbal expression of dissatisfaction or disquiet in relation to the location's exercise of its functions in relation to its current individuals. The Manager is responsible for the thorough investigation of all complaints and should take responsibility for ensuring that investigations undertaken by others are in line with the best practice standards required. A confidential record of all complaints received is to be documented on a Record of Complaint form and shall be kept in the Complaints File, which all locations must maintain.'

Managers stated informal complaints were largely raised through the advocate. The advocate recorded all issues on a feedback form and these forms were retained at the premises. The advocate would then respond to the issues, as required, with both the staff and the patient raising the issue, providing feedback as required. The statistics for informal complaints received in 2018 were as follows:

- Jan – March 2018 - 9 informal complaints to advocacy
- April – June 2018 - 10 informal complaints to advocacy

We reviewed the advocacy sheets and found the managers comments box to be empty on each one since 30 January 2018. We were unable to see whether patient complaints had been responded to and whether any lessons learned were identified or shared with staff. Two patients reported they had raised complaints and had not received any feedback on them.

We found some staff attitudes to be dismissive of patients, particularly of those who frequently raised complaints about their care and treatment. We reviewed the response to four complaints that the managers had categorised as formal. Three complaints were raised by carers or professional bodies. One complaint was raised by a patient and had been managed differently to the others. It did not include a thorough investigation, or involve other professional bodies including advocates to support the patient. The decision recorded in the letter sent to the patient was that this complaint would be dealt with informally, without a clear rationale in the complaint record as to why this was the case.

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

Long stay/rehabilitation mental health wards for working age adults

Not sufficient evidence to rate

Not sufficient evidence to rate

Good governance

Systems that were in place to ensure good governance of the hospital were not being operated effectively. The referral and admission process was not ensuring that patients being admitted were appropriate for the environment or purpose of the ward and not in line with their statement of purpose. Staffing levels were not sufficient to ensure that rehabilitation could be delivered in a safe and comfortable environment and the provider did not monitor whether patients had access to one to one time with staff. There were high numbers of incidents of violence and aggression and patients felt unsafe. There was a lack of evidence of low level incidents being reviewed and learned from. The provider's policy on staffing levels for increased observations was not clear and staff were not therefore interpreting this correctly or adhering to it.

Staff were not meeting the physical health needs of one patient who was presenting as acutely unwell and one patient who had a diagnosed physical health condition. The on call medical rota did not enable a doctor trained in resuscitation to be immediately available in an emergency. Staff lacked the knowledge and skills needed to effectively support patients with a diagnosed learning disability in a rehabilitation and recovery environment. Managers did not monitor all complaints or respond to them in line with the provider's policy.

The hospital was not reporting incidents to CQC as required. Between 1 May 2018 and 20 June 2018, there were thirteen notifiable incidents under Registration Regulation 18 (2009) of the Health and Social Care Act. Of these, none were sent to CQC. On six occasions, staff had documented on the incident reporting form that CQC had been notified. The acting manager reported all incidents requiring notification had been sent to CQC. This meant that as a regulator, CQC were unaware of the level of incidents that were occurring in the hospital and that managers were not complying with their statutory duties under the Act.

Leadership, morale and staff engagement

Ten current and previous staff members reported concerns about ineffective leadership, lack of professionalism, lack of visible management, a culture of bullying and low morale amongst the team. Staff reported they had previously been afraid to voice their concerns for fear of repercussions. Staff reported that the high staff turnover levels were in part due to the management within the hospital and the levels of violence and aggression. One staff member felt recruitment wasn't always robust and that people were employed due to their availability as opposed to suitability.

We requested exit interviews for staff leavers and gathered feedback from previous staff members. A review of six exit interviews indicated the lack of management support and assaults to staff were a contributory factor in leaving. Previous staff members raised concerns about staffing levels, the safety of the ward and the risks posed by the patients along with poor management practices.

There was a lack of clinical leadership for support staff and a lack of cohesive team working between the two staff groups. This meant that support staff were often working autonomously. Three of the six nursing staff had less than two years experience and the current vacancy had been filled by a newly qualified nurse due to start in September 2018.

Comments from staff included "we are undervalued and we are overruled" "our feedback isn't welcome" "high level of stress all the time" and "we are expected to get on with it". Support staff stated they relied on each other and taught each other what they needed to know as "the managers don't bother with us and leave us to sort ourselves".

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that care and treatment is appropriate to all service users, meets their needs and reflects their preferences.
- Staff must ensure that if they have concerns about a patient's capacity, they assess their capacity and ability to consent on a decision specific basis.
- The provider must ensure there are sufficient staff to safely meet the care and treatment needs of the patients. The provider must ensure staff have the knowledge and skills to support patients with a learning disability and that staff use an appropriate model of care to support this patient group.
- The provider must ensure that a doctor trained in resuscitation is available to immediately attend in an emergency if restrictive interventions may be used.
- The provider must ensure that all patients prescribed medication have all the required monitoring of side effects undertaken as per national guidance.
- Staff must ensure that they take all reasonable steps to ensure the required physical health monitoring of patients receiving high dose anti-psychotic medication is undertaken, in line with the provider's policy.
- Staff must ensure that patients are treated with dignity and respect.
- Staff must ensure that all complaints are recorded, monitored and investigated in line with the provider's policy.
- Staff must ensure that systems and processes are operated effectively to monitor the quality, safety and risks to the welfare of the patients and staff.
- The provider must ensure they monitor that patients are able to access one to one time with staff.
- The provider must ensure that all incidents are reviewed and lessons learned are identified to prevent future harm.
- The provider must ensure that their policy on increased observations is clear and that staff adhere to this.

Action the provider SHOULD take to improve

- The provider should ensure that leadership is visible and supportive and that the team work closely together in an environment where they feel valued and able to raise concerns if needed.
- The provider should ensure that all restrictions in the environment are based on an individual assessment of risk and are documented and reviewed.
- The provider should consider the models of care used for risk assessment to ensure this meets the needs of the patient group.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Staff did not ensure that patients were treated with dignity and respect. This was a breach of Regulation 10 (1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for patients because the service was not regularly assessing the risks to the health of patients by ensuring there was proper monitoring of long-term anti-psychotic use. A doctor trained in resuscitation was not immediately available to respond in an emergency. This was a breach of Regulation 12 (1) (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Staff did not ensure all complaints were investigated or operate an effective system for responding to complaints by patients in line with the provider's policy. This was a breach of Regulation 16 (1) (2)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Staff did not operate systems and processes effectively to ensure they assessed, monitored and mitigated the quality, safety and risks to the welfare of the patients and staff.

This was a breach of Regulation 17 (1) (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Warning notice issued:** Staff did not ensure that care and treatment being delivered was appropriate for all patients, met their needs and reflected their preferences. This was a breach of Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Warning notice issued: The provider did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the needs of all patients. This was a breach of Regulation 18 (1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider did not notify the Commission without delay of incidents of any abuse or allegation of abuse in relation to a service user on three occasions. This was a breach of regulation 18 (1) (2) (e)