

Cygnnet Views

Quality Report

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

Ratings

Overall rating for this location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



Overall summary

We carried out a focused inspection of Cygnnet Views in response to a number of concerns. We looked at areas relating to the safe, responsive and well led domains. The rating of the well led domain changed to requires improvement and this meant that the overall rating for the hospital was requires improvement. The reason for this was as follows:

- Staff did not always follow infection prevention and control guidance specific to the COVID-19 pandemic. There had been an outbreak of COVID-19 earlier in

year. Following the inspection, we issued a warning notice about this and told the provider they must improve staff infection prevention and control practices to keep people safe during the COVID-19 pandemic.

- There were not always enough staff on duty to keep patients safe. There had been a shortfall in the number of support workers required and this had particularly

Summary of findings

affected night shifts where there was a high use of bank staff. Whilst the provider had recognised the need to increase the numbers of qualified nurses in the hospital, this still needed to be fully implemented.

- There had been an improvement in staff culture since the last staff surveys in July 2020. However, there were still areas for improvement so that the whole staff team felt positive about working for the provider and valued and supported by their managers.
- The culture described by patients and carers was not always positive. Some patients and carers said that staff were not always kind to patients.
- Our findings from the other key questions demonstrated that governance processes did not always operate effectively and that this meant not all processes were implemented consistently to ensure patient safety, staff safety and consistent learning. For example, not all staff knew where ligature risks were on the ward.
- The service had not ensured that their reception area was secure and identifiable information was not stored securely at the time of our inspection.

- Learning from incidents and complaints was inconsistent. Not all staff were aware of this learning being shared. Staff did not consistently receive a debrief after an incident that would require one.

However:

- Staff were supervised and appraised and compliance levels for this were at 90% for the service. Managers dealt with poor staff performance when needed.
- The ward environments were safe and clean. Staff assessed and managed patients' individual risks well, managed medicines safely, followed good practice with respect to safeguarding and minimised the use of restrictive practices.
- The hospital managed discharge well and discharges were only delayed if there was a delay in community provision. Staff planned patients' discharge and worked with other professionals well.
- Leaders had a good understanding of the services they managed and had plans where improvements were required.
- Staff had access to the risk register. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register.

Summary of findings

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Requires improvement 

Cygnnet Views

Services we looked at

Wards for people with learning disabilities or autism

Summary of this inspection

Background to Cygnet Views

Cygnet Views is an independent hospital situated in Matlock, Derbyshire. The hospital provides care and support for up to ten women with learning disabilities, challenging behaviour and complex mental health needs. At the time of our inspection there were eight patients.

At the time of our inspection, there was a registered manager who is a person who had registered with the Care Quality Commission to manage the service. The registered manager had come started in post July 2019. The registered manager has a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations. There was a new locum consultant psychiatrist who had started in post in July 2020.

Cygnet Views are registered with the CQC for:

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

- Treatment of disease, disorder or injury

We last inspected Cygnet Views in August 2018. We rated the service as good overall. We rated the service as requires improvement in safe and good in effective, caring, responsive and well led.

At our last inspection we identified that the provider was in breach of Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

The provider did not ensure that staff complied with dress code and personal appearance policy. This meant that some staff posed a risk to infection control and patients' physical safety.

At this inspection we did not find that this had improved.

Our inspection team

The team that inspected the service comprised two CQC inspectors, an inspection manager, a specialist advisor; a nurse who had experience of working in learning disability services and an expert by experience, who had a family member who used learning disability services.

Due to the COVID-19 pandemic only one inspector and specialist advisor visited the site. The other team members carried out the inspection from remote locations and spoke to staff by telephone.

Why we carried out this inspection

We carried out this unannounced focused inspection following a review of our intelligence about this service and information of concern received from stakeholders. We received four whistle blowing concerns which had been raised by staff who wished to remain anonymous. The whistle blowing themes were concerns about; patient safety, staff safety, staffing, incident reporting, leadership support and staff behaviour.

This was a focused inspection, we mainly looked at the safe and well led key lines of enquiry. Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have

identified a breach of a regulation and issued a requirement notice or taken action under our enforcement powers; in these cases the ratings will be limited to requires improvement or inadequate.

Previous ratings were not all updated at this inspection. However, the well led rating went down from good to requires improvement. The service overall rating therefore changed to requires improvement.

Following the inspection, we issued a warning notice. We told the provider they must improve staff infection prevention and control practices to keep people safe during the COVID-19 pandemic.

Summary of this inspection

How we carried out this inspection

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.

This was a focused inspection and therefore our inspection activity focused on specific areas. This means we did not look at all key lines of enquiry in each of the domains.

During the inspection visit and through our remote activity, the inspection team:

- visited the ward at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- spoke with three carers and family members of patients who were using the service

- spoke with the registered manager and regional director of nursing
- spoke with 26 staff members; including a doctor, nurses, occupational therapist

psychology staff and support workers, some of these staff were bank staff

- received feedback about the service from an advocate, the local authority safeguarding team and other key stakeholders
- looked at four care and treatment records of patients
- looked at eight staff files
- 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 service say

We spoke to four patients and three carers about the service.

Patients told us that the ward was clean, and that staff wore their face masks.

Patients told us there were not always enough staff and this had been a particular problem recently. They told us that staff did not always have time for one to one appointments with them and that there were not always staff to go out on leave with. They explained they often had to wait for staff to become available.

Their feedback about staff was mixed; overall, they reported that most staff were kind and looked after them, but there were two patients who identified some staff as being unkind.

One patient said their complaints are not always listened to and two patients said they were not aware that staff supported them with a debrief after incidents.

All the patients talked about experiencing aggression from other patients, one patient raised a safeguarding concern about another patient. They reported feeling unsafe on the ward. We discussed this with the hospital manager who dealt with the concerns.

One carer told us that staff were friendly and communicated well with them and that there were enough staff and that their family member was safe

Two carers told us they had concerns about staffing and that there had been lots of changes to staffing. One of these carers said that they did not think the staff were always suited to their roles and could be verbally aggressive to patients. They told us that there were cancellations to outings and more activity would be beneficial for the patients.

Carers gave positive feedback about leadership at hospital and ward level. Overall, they felt that their family members were making progress. One carer told us that they thought that staff could improve communication with them.

After our inspection the provider explained that patients' one to ones and appointments were not cancelled but

Summary of this inspection

were sometimes postponed. For example, this might happen if another patient had an urgent medical appointment or if there was another matter that took priority.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not change the rating of the safe domain and this remained requires improvement.

Requires improvement



- Staff did not always follow infection prevention and control guidance specific to the COVID-19 pandemic. The service had an outbreak of COVID-19 earlier in year. Staff did not do all that was required to prevent and control infection.
- There were not always enough staff on duty to keep patients safe. There had been a shortfall in the number of support workers required and this had particularly affected night shifts where there was a high use of bank staff. Whilst the provider had recognised the need to increase the numbers of qualified nurses in the hospital, this still needed to be fully implemented.
- Not all staff were able to identify potential ligature risks in the ward environment and staff were unable to tell us where the ligature risk assessment was located.
- The service had not ensured that their reception area was secure and identifiable information was not kept securely at the time of our inspection.
- Learning from incidents was inconsistent. Not all staff were aware of this learning being shared. Staff did not consistently receive a debrief after an incident that would require one.
- At the time of our inspection not all staff were trained in basic life support, 78% of staff were up to date with this and this meant staff may not have been able to respond to patients who needed life support.

However:

- The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff managed individual patient risk well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint as a last resort.
- 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.

Summary of this inspection

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

Are services effective?

The domain was not inspected. The rating remained good.

Good



Are services caring?

The domain was not inspected. The rating remained good.

Good



Are services responsive?

We did not change the rating of the responsive domain. The rating remained good.

Good



- The hospital managed discharge well and discharges were only delayed if there was a delay in community provision. Staff planned patients' discharge and worked with other professionals well.

However:

- Not all staff were sure they received feedback from complaints. Team meetings did not have a set agenda which included complaints and there had been no recent feedback about complaints.

Are services well-led?

We rated well-led as requires improvement because:

- Our findings from the other key questions demonstrated that governance processes did not always operate effectively and that this meant not all processes were implemented consistently to ensure patient safety, staff safety and consistent learning.
- There had been some improvement in culture since the last staff surveys in July 2020. However, there were still areas for improvement so that the whole staff team felt positive about working for the provider and valued and supported by their managers.
- The culture described by patients and carers was not always positive. Some patients and carers said that staff were not always kind to patients.
- Not all staff were aware of the role of the Freedom to Speak up Guardian.

However:

- Leaders had a good understanding of the services they managed and had plans where improvements were required.

Requires improvement



Summary of this inspection

- Staff had access to the risk register. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register.
- Staff were supervised and appraised and compliance levels for this were at 90% for the service. Managers dealt with poor staff performance when needed.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	N/A	N/A	N/A	N/A	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Wards for people with learning disabilities or autism

Safe	
Responsive	
Well-led	Requires improvement 

Are wards for people with learning disabilities or autism safe?

Safe and clean environment

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced risks they identified. Staff completed monthly risk assessments of the environment and in-depth risk assessments annually. We reviewed the health and safety audit that the hospital manager had completed in August 2020 and the service was compliant in all areas.

Staff could not observe patients in all parts of the ward. The ward was situated over three levels and there were narrow corridors, therefore there were not clear lines of sight. The staff positioned themselves throughout the ward to maintain sight of patients and patient's observations were increased where required.

There were reduced ligature fittings on the ward but there remained ligature anchor points. A ligature point is anything that patients could attach a cord, rope or other material for the purpose of hanging or strangulation. There were ligature cutters available in two locations on the ward and staff knew where to locate these.

Most staff we asked could not identify key ligature anchor points and staff were unable to tell us where the ligature risk assessment was located. The ligature risk assessment identified where ligature anchor points were located. This meant not all staff were aware of the potential ligature risks in the ward environment.

The service had not ensured that their reception area was secure. The reception area contained confidential information and patient identifiable information. The provider had recently moved the location of the reception, but this was not in an environment which was secured. At the time of our inspection we entered the reception on two occasions when there were no staff and there was identifiable information accessible.

The hospital accommodated female patients only. This complied with national guidance about, and expectations governing, the provision of single sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems. We saw that all staff carried alarms.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Staff had increased the frequency of cleaning in response to the COVID-19 pandemic.

Staff did not always follow infection prevention and control guidance specific to the COVID-19 pandemic. The service had experienced a significant outbreak of COVID-19 earlier in year. We observed three members of staff wearing their masks incorrectly, so they did not cover their faces. Three members of staff had false nails and nail varnish. This was an issue we had identified as a breach of the Health and Social Care Act regulations at our last inspection.

During the inspection, we saw the main personal protective equipment station where staff donned and doffed their masks did not have hand sanitiser available. When we asked about this, the hospital manager explained the hand sanitiser had been moved to another area of the hospital. They replaced this when we said we had observed that there was none available. Not all staff knew when to wash their hands when donning and doffing masks and where they should dispose of used masks. We observed four staff donning and doffing masks without using hand sanitiser correctly and when staff disposed of used masks there was no foot pedal operated clinical waste bins. This meant staff touched the bin lid as they disposed of masks. Staff did not adhere to Public Health Guidance and this posed an infection control risk.

Clinic room and equipment

The clinic room was fully equipped with accessible resuscitation equipment. Staff checked emergency drugs

Wards for people with learning disabilities or autism

regularly. There was a problem with the medicines fridge which had required several resets to ensure medicines stayed safe, but the provider had plans in place to have this resolved.

Staff checked, maintained, and cleaned equipment. The clinic room was visibly clean and tidy.

Safe staffing

There were not always enough staff on duty to make patients safe. The service required four whole time equivalent qualified nursing staff. There were two whole time equivalent vacancies at the time of our inspection. Support worker establishment levels were sixteen (WTE) support workers. There were three vacancies for support staff.

The provider had an ongoing staff recruitment programme. The hospital manager and the human resources team met weekly to discuss staffing at the hospital. There were interviews planned and six support workers had been recently recruited.

The service regularly used bank staff and less frequently agency staff. This was particularly common on night shifts where staff identified a shortage of regular staff. We reviewed rotas and saw that between 9 and 23 September 2020, 13 of 15 night shifts had been filled by agency nurses. Between 13 July and 9 August 2020 all night shifts were filled by an agency nurse. The provider normally used agency and bank staff who worked regularly at the service and therefore knew the patients.

The service was keen to recruit more nursing staff so that they were overstaffed and so that they could ensure the service was led by nursing staff alongside the other multidisciplinary team members. The service had recently introduced the role of a nursing associate and wanted to further increase the number of nursing associates.

The service relied heavily on bank staff for non-qualified support worker roles. Again, we particularly saw this at night where there were less regular support workers on shift. Bank staff formed most of the night staff available. The service had some bank staff who only worked at this hospital but also used regional bank staff. However, the service had recently recruited six new support workers.

The provider ensured bank and agency staff had a full induction and understood the service before starting their shift. We spoke to bank staff who confirmed this.

Because of the hospital's COVID-19 outbreak, staff sickness levels had been high in the six months prior to our inspection. Staff sickness was at a 14% average from 1 March until 31 May 2020. However, as staff recovered this fell to a 2% average from 1 June until 31 August 2020.

The staff turnover rate was high but reducing. There had been a 61% turnover in the 12 months prior to our inspection, however this was reducing. In the three months prior to our inspection this had reduced to 8% and in the last month to 4%. The hospital manager told us staff turnover had been high because of staff leaving to attend further education opportunities.

Safe staffing requirements were one qualified nurse and six support workers, one of who was in the role of therapy coordinator on day shifts and one qualified nurse and four support workers on night shifts. These staffing could include one enhanced observation where a member of staff was required to support a patient constantly on a one to one basis. If there were additional enhanced patient observations required, then additional staff were sought.

There were not always enough support staff to keep patients safe. Night staff said they worried about staff and patient safety because of staffing. They said there were frequent night time staffing shortages. Between the 9 and 23 September 2020 there had been a shortfall in the number of support workers required on shift for 10 of 15 occasions on night shifts. On eight occasions there had been one member of staff short and on two occasions there had been two members of staff short.

Night staff told us that when staff numbers fell below five, they did not have adequate staffing to respond if there was an incident. Therefore, they did not always feel prepared to carry out physical interventions. They explained that less than five staff meant that they were not sure that they could provide a response team to incidents on the ward. Staff said that there had not been any incidents due to them not having enough staff, but they worried that if an incident took place, they would not be able to respond to it.

The provider ensured there were enough qualified nurses to keep patients safe. Where sickness and absence had affected nursing numbers the hospital manager and regional operations manager had worked on shift as they were qualified nurses

Wards for people with learning disabilities or autism

Staff told us that there were not always enough staff to facilitate one to one time with patients.

Staff said that sometimes patient's leave was cancelled or delayed due to staffing. All four patients we spoke with told us they could not always go out when they wanted to.

We asked all staff about their views of whether there were enough staff. Overall day time staff said they had enough staff on shift. They explained that they could call on the therapeutic coordinator from the and multidisciplinary staff to support the ward if required. However, staff told us that enhanced observations took priority, and this meant that there was sometimes an impact on other activities on the ward. Night-time staff were concerned about staffing levels and did not think there were enough staff for a significant number of shifts.

Medical Staff

The service had enough daytime and night time medical cover and a doctor was available to go to the ward quickly in an emergency. The hospital shared a consultant psychiatrist and a speciality doctor with another local Cygnet hospital. There was additional out of hours cover if required.

Mandatory training

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

At the time of our inspection overall compliance for mandatory training was 94%. Nine of the 16 mandatory courses had a compliance rate of 95%, this included infection prevention and control. All courses apart from basic life support had a compliance rate of above 90%. However, basic life support had a compliance level of 78%. This meant not all staff may have been able to respond to patients who needed life support.

The provider made autism awareness training available to staff. In addition, there was training booked for staff in October 2020 which included; reducing restrictive practice, suicide and self harm, meaningful engagement and sensory strategies, trauma informed care, relational boundaries, physical health and dysphagia.

Assessing and managing risk to patients and staff

We reviewed four care records in detail.

Staff completed risk assessments for each patient on admission and used recognised tools. Staff used the Short

Term Assessment of Risks and Treatability risk assessment. We also saw Historical Clinical Risk Management 20 risk assessments in some care records. Staff reviewed risk assessments regularly, including after incidents. Staff developed and reviewed risk management plans for identified risks.

Assessment of patient risk

Staff knew about risks for each patient and acted to prevent or reduce risks. All staff, including bank and agency staff, demonstrated a good understanding of patients they cared for.

Staff assessed specific issues such as falls, epilepsy, sepsis and choking risks.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff understood patients' risks and triggers and followed individualised plans to manage risks with patients. Staff recorded their actions and interventions in care and treatment records.

Staff met to discuss patient risks. Staff met at two handovers each day. In addition to this there were daily risk assessment meetings, and these were attended by the ward nurse and the multi-disciplinary team members. Patients' individual risk rating was assessed and rated and care plans reviewed.

Use of restrictive interventions

The provider had a restrictive interventions reduction programme which met best practice standards. The provider delivered training sessions for all staff to improve staff understanding of restrictive interventions. We saw that reducing restrictive interventions had been discussed in team meetings.

Care records evidenced staff made every attempt to avoid using restraint with patients. Staff used de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Between 1 June and 31 August 2020 staff had used restraint on 66 occasions. Staff had used prone restraint on two occasions, prone restraint is face down restraint and is not recommended as good practice. We asked the provider about these and they explained the reason for staff to use prone restraint was because they allowed the patient to lead into restraint the way that the patient wanted to. They then moved the patient out of this position as soon as they

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were able to safely do so. Staff had carried out one other restraint during this time where the patient had been placed into supine position which is face up. Most other restraints involved low level interventions and when we reviewed care records and restraints, we were satisfied that staff attempted to deescalate patients to avoid restraint but where they were unable to do so staff used the least restrictive intervention that they could.

The service had not used rapid tranquillisation in between the period between 1 June and 31 August 2020.

The service had not used seclusion or long-term segregation the period between 1 June and 31 August 2020.

Safeguarding

The provider made training on how to recognise and report abuse available to staff. When we inspected, 92% of staff had completed safeguarding training and all senior staff who were required to complete level 3 safeguarding training had done so.

Staff could give clear examples of how to protect patients from harassment and discrimination. Staff knew how to keep patients safe from harm and reported incidents that took place between patients.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The hospital had a safeguarding link worker who worked for the local authority safeguarding team. There were quarterly meetings where the hospital manager and the local authority met to discuss any safeguarding concerns.

Staff knew how to make a safeguarding referral and discussed concerns with the hospital manager who took the lead for safeguarding.

Staff access to essential information

Patients' care records were comprehensive, and most staff could access them easily. There was information stored on an electronic records system however there were also paper records. However, not all staff had a password for the electronic system to access patient's notes. Two staff told us this was a problem. This meant staff could not easily access and record in patient's records. The hospital manager was aware of this and was trying to resolve this issue.

Positive behaviour support plans and information sheets about patients were easily accessible to staff in the nursing office.

Medicines management

Staff followed systems and processes for prescribing, administering, recording and storing medicines. We reviewed medicines record and saw staff reviewed patients' medicines regularly and effectively. Staff completed medicine cards correctly including recording patients' allergy status. A pharmacist who worked for an independent pharmacist monitored, and audited medicines related activity. Staff followed correct protocols for the administration and reviews of as required medicines.

Staff reported medicines errors in line with the provider's policy on reporting incidents. and were provided with appropriate medicines supervision and competency assessment.

Doctors ensured people's behaviour was not controlled by excessive and inappropriate use of medicines and the service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Track record on safety

There had been no serious incidents reported at the service in the last six months.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Overall staff knew how to report incidents and did so when required. We observed that incidents that should have been reported were reported.

Staff raised concerns and reported incidents and near misses in line with the provider's policy. We reviewed incidents reported from 1 April 2020 until the date of our inspection. Staff reported when late observations took place. Other incidents staff recorded included; incidents of violence and aggression towards staff, patient on patient violence or aggression, self-harm and environmental risks. We saw staff recorded incident reports in individual patient care records when they involved patients.

The provider kept a record of incidents reported at the hospital. There were 638 incidents reported since 1 April 2020. Of these incidents staff recorded 204 as minor harm,

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417 as no harm/negligible and staff recorded these 17 as moderate harms. Most incidents were for violence and aggression either between service users or towards staff or for patient self-harm.

Debriefs did take place but this did not happen consistently. Staff gave us mixed feedback about whether they were well supported and debriefed after incidents. We saw written evidence of debriefs which were thorough and considered staff experience and learning lessons. However, there were examples described by staff where patient on staff assaults had taken place, patients had been racist towards staff, but that staff were not supported through a debrief process.

Managers investigated incidents. The provider had supported the hospital manager with training in completing investigation. In the interim there had been support provided by the provider's senior managers for the investigations. We saw evidence staff reviewed incidents in the daily risk meeting and at clinical governance meetings. We reviewed incidents and saw staff took appropriate actions in response to incidents.

There was some learning from incidents, but this was not consistent and not all staff were sure they received learning from incidents. Staff discussed incidents at the morning risk meeting. Staff told us that they discussed incidents at team meetings, supervisions and handover, but we did not see that learning from incidents was recorded in handover meetings or team meetings. For example, at team meetings there was no standard team meeting agenda item for sharing information about incidents or that incident learning was shared. We asked staff about a specific incident that had taken place but not all staff were aware of what the learning was from this.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Access and discharge

Where the hospital had delayed discharges, these were normally due to a lack of availability of community

placements. We reviewed care records and saw that discharge pathways were clear, and that patient led discharge was a priority. There had been no delayed discharges in the 12 months prior to our inspection.

Where patients had become unsuitable for the service staff reviewed this and supported patients where required to be discharged to a more suitable environment.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We reviewed care records and saw that discharge pathways were clear, and that appropriate discharge was a priority. The hospital managers demonstrated a good understanding of individual patient's care pathways and prioritised these.

Listening to and learning from concerns and complaints

Patients told us knew how to complain or raise concerns. Two of the three carers we spoke with told us they knew how to make a complaint.

The service clearly displayed information about how to raise a concern in patient areas. Easy read accessible information was available for patients about how to make a complaint or raise a concern.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes and fed back in monthly clinical governance meetings. The service had recorded four complaints in the two months prior to our inspection and these had been responded to within five days, this was well within the time frame set by the provider set for responding to complaints. One of these complaints had not been upheld. No complaints had been referred to the Parliamentary Health Service Ombudsman.

There was a low level of complaints. Not all staff were sure they received feedback from complaints. Team meetings did not have a set agenda which included complaints and there had been no recent feedback about complaints.

There was 'compliments tree' in a staff meeting room and compliments were discussed during meetings. We saw compliments were recorded and discussed in clinical governance meetings.

Wards for people with learning disabilities or autism

Are wards for people with learning disabilities or autism well-led?

Requires improvement 

Leadership

The hospital manager was a qualified nurse, they were new to a leadership role, and had been in position for one year. The provider had supported the hospital manager in their new role with support and visits from senior managers. The hospital had a significant outbreak of COVID-19 earlier in 2020 and this had increased pressure on the service. Senior provider managers had therefore recruited an experienced qualified nurse to support the manager in their role.

Leaders had a good understanding of the services they managed. They could explain how the teams were working, new developments and the challenges they faced. The hospital manager, regional operational director and regional director of nursing had a good understanding of all aspects of the hospital and had plans where improvements were required.

There had been a staff survey carried out for Cygnet Views in July 2020. Twenty-five staff completed this, which was over 80% of the staff team and over half of these staff said they did not think that senior managers were regularly visible. At our inspection we asked staff about this and saw that overall staff felt this had improved, but there was a group of staff who did not describe seeing managers regularly or feeling they were approachable. The regional operational director and director of nursing had increased their visibility at the service in recent months and the service had a plan to conduct another staff survey in October to assess whether improvement had taken place since July 2020.

Leadership development opportunities were available, including opportunities for staff below team manager level. Cygnet had a nursing associate programme and there were leadership development opportunities for the hospital manager. There were roles for support workers as team leaders who led the shift with the nurse in charge.

Culture

Not all staff felt respected, supported and valued but there were staff who had noted improvements in respects to this. However, not all staff were happy and there was a small group of staff who were clearly dissatisfied.

Not all patients and carers were positive about the culture at the hospital. Two of the four patients we spoke to told us that they did not always think staff were kind to them. One of the three carers we spoke to told us that they did not think staff were always well suited to their role and could be verbally aggressive to patients.

Not all staff felt positive and proud about their work for the provider and their team. Not all staff had felt well supported during the local outbreak of COVID-19 at the hospital and not all staff thought this had been well managed. The COVID-19 outbreak had placed extra pressure on the service and had clearly affected staff morale.

Staff told us they were able to raise concerns without fear of retribution. Overall staff felt confident they could raise concerns and staff told us about concerns that they had raised.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. Staff told us they knew how to report concerns and the Freedom to Speak up Guardian for the organisation had recently visited the unit to speak to staff. However, not all staff, particularly night and bank staff were aware of the role of the Freedom to speak up Guardian. We spoke to the Freedom to speak up Guardian who said that staff had come to speak to them openly when they had visited the unit in the week prior to our inspection. After our inspection the hospital manager told us there were regular communications sent to staff and posters displayed that explained to staff the role of the Freedom to Speak up Guardian.

Managers dealt with poor staff performance when needed. We reviewed eight staff personal files and we saw that where there were concerns about performance they were addressed with actions.

Staff told us they worked well with their colleagues and spoke highly of their team members. However, there were differences in the team about how supported they felt by managers. This was a potential issue for team cohesion and impacted on the way the whole team worked together.

Wards for people with learning disabilities or autism

Staff had completed appraisals and these included conversations about career development and how it could be supported. Hospital staff were supervised, and supervision compliance was at 90% on average between June and August 2020. Appraisal and supervision completion for the multidisciplinary team staff was monitored in clinical governance meetings.

Staff had access to support for their own physical and emotional health needs through an occupational health service. There was an employment support service for staff.

The provider recognised staff success within the service through staff awards. Also, locally managers showed their appreciation of staff by giving positive feedback and providing them with rewards.

Governance

Governance at the service was not always effective. For example, there had been lapses in infection prevention and control in relation to COVID-19. Staff were not aware of ligature points and did not know where the ligature risk assessment was for information about ligature points.

Processes were not always consistently applied such as debriefs and learning from incidents or complaints. There was no clear framework of what must be discussed at team meetings to ensure staff shared and discussed essential information, including learning from incidents and complaints. Identifiable information had not been kept confidential in the reception area.

Staff undertook or participated in local clinical audits. There was a regular provider audit cycle and the hospital staff ensured that these were in carried out and that actions were taken.

Management of risk, issues and performance

Staff had access to the risk register. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register. Those concerns on the risk register included patients of concern, COVID-19 and low staffing numbers.

The service had plans for emergencies which included COVID-19.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must improve staff infection prevention and control practices to keep people safe during the COVID-19 pandemic. Regulation 12
 - The provider must ensure there are enough staff including qualified nurses on duty to meet the complex needs of the patients. Regulation 18
 - The provider must ensure that staff know where staff where potential ligature risks are in the ward environment. Regulation 17
 - The provider must ensure that governance processes are in place to ensure that:
1. Learning from incidents and complaints takes place consistently and discussion is recorded.
 2. All debriefings take place with relevant staff in attendance, where required, following incidents.

3. Information governance is in place to ensure that confidential and identifiable information is kept securely.

Action the provider **SHOULD** take to improve

- The provider should ensure all staff are aware of who the Freedom to Speak up Guardian is and how to contact them.
- The provider should ensure that all staff are able to access patient's care records to review and record information about patients.
- The provider should ensure that they work to improve the culture and satisfaction of patients, carers and hospital staff to improve service user and carer experience and the cohesion of the staff team.
- The provider should ensure that staff complete their basic life support training.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure staff followed infection prevention and control practices to keep people safe during the COVID-19 pandemic.