# Cygnet Hospital Wyke

## 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

| | |
|---|---|
| Are services safe? | |
| Are services well-led? | |

### 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.

## Overall summary

This was a focussed inspection based on concerns we had received about the safety of Fairfax ward. Ratings have not been given for this inspection.

We found the following issues that the provider needs to improve:

- The management of environmental risks was poor and we had concerns about the management of

medication. Not all staff were trained in areas, which would help to ensure that patients were cared for safely and which reduced the risk of harm. There was not a clear process in place for staff to assess and manage patients' risks in areas such as their mobility, eating and drinking and in relation to needs for the use of restraint. When risks were identified, staff had not taken action to reduce risks and prevent harm.

- Staff did not record whether they had used de-escalation techniques with patients prior to the use of restrictive physical interventions. Staff did not record exceptional circumstances for the use of prone restraint.
- The governance systems in place did not ensure the delivery of safe and high quality care. Staff did not always follow guidance and procedures set by the provider. Internal audit and governance systems had not highlighted concerns we identified on inspection such as the poor recording of restraint and the increased falls taking place on the ward. We had made previous recommendations to the provider, which they have not acted upon to improve, the safety and quality of patient care.

However, we also found the following areas of good practice:

- The provider responded quickly to our concerns and made immediate improvements to enhance patient safety.
- Patients were engaged in activities during our inspection.

# Summary of findings

## Contents

# Cygnet Hospital Wyke

**Services we looked at:**
Wards for older people with mental health problems

# Summary of this inspection

## Background to Cygnet Hospital Wyke

Cygnet Hospital Wyke is registered with the Care Quality Commission to carry out the following regulated activities:

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

A registered manager was in place at the location. 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 including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2010.

An accountable officer was also in place. The accountable officer is a senior manager who is responsible and accountable for the supervision, management and use of controlled drugs.

Cygnet Hospital Wyke is a 55 bedded purpose built independent mental health hospital caring for patients across three wards:

- Austen ward a male inpatient psychiatric intensive care unit with 14 beds.
- Branwell ward a male acute inpatient mental health ward with 19 beds.
- Fairfax ward a male ward for older people with mental health problems and challenging behaviours with 22 beds.

We last carried out a comprehensive inspection of this service in June 2015. At that inspection we rated the service as 'good' overall, with a rating of requires improvement in the safe key question. The hospital was in breach of two regulations

- Regulation 13 – safeguarding service users from abuse and improper treatment.

The provider had not introduced measures to reduce the use of prone (chest down) restraint.

- Regulation 15 – premises and equipment.

The seclusion room did not meet national guidelines.

We returned to the hospital in July 2016 to check that the provider was now compliant with the regulations, and to respond to some specific concerns about Fairfax ward. We found that the provider continued to be in breach of regulation 15 because Fairfax ward was not clean.

## Our inspection team

Team leader: Gemma Berry, Inspector.

The team that inspected the service comprised one CQC Inspection Manager and three CQC inspectors including the team leader.

## Why we carried out this inspection

We carried out this unannounced inspection on Fairfax ward in response to concerns we had received from carers and other stakeholders about the safety of patients. These concerns related particularly to falls and the use of restraint.

Fairfax ward provides care for up to 22 older male patients with mental health problems.

# Summary of this inspection

## How we carried out this inspection

We asked the following question of Fairfax ward only:

- Is it safe?
- Is it well led?

Before the inspection visit, we reviewed information we had received about the ward from carers and stakeholders, including notifications made to us about safeguarding concerns and incidents occurring on the ward.

During the inspection visit we:

- visited Fairfax ward and looked at the quality and safety of the environment
- spoke with seven members of staff including the ward's occupational therapist, qualified nurses and healthcare support workers
- looked at the care and treatment records of four patients
- reviewed the medication charts of all patients admitted to the ward
- looked at specific policies and procedures relating to the management of the ward
- reviewed incidents of restraint
- reviewed incidents where patients had fallen or received an injury during their admission to the ward.
- carried out observations using the short observational framework for inspection
- reviewed staff training.

# 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?

This was a focused inspection in relation to concerns raised about Fairfax ward. Ratings have not been given for this inspection. We have written to the provider following the inspection to advise them of immediate actions they must take to ensure patients are cared for safely.

We found the following issues that the provider needs to improve:

- The ward environment had not been adequately risk assessed. There were ligatures in the communal lounges, which were not included on the ligature risk assessment. Several areas of the ward were unsafe for patients with mobility difficulties such as an uneven floor, a lack of appropriate signage to orientate patients and lack of accessible lighting.
- Not all staff had undertaken the required mandatory training. Not all staff had completed all of the required training in relation to prevention and management of violence and aggression. Only one staff member (3%) had completed training in relation to moving and handling people.
- We had concerns about the management of medicines. One patient had not received adequate physical health monitoring and staff had given other patients medications covertly without appropriate care plans and the involvement of a pharmacist.
- Staff did not assess and manage patient risk where there was a clear need for intervention. They had not adequately assessed patients at risk of falls to reduce and prevent the risk of harm.
- Staff did not report all safeguarding concerns to the local authority and the Care Quality Commission.
- There was no protocol or guidance in place for staff to support patients at risk of choking.

However we found the following areas of good practice:

- The ward was clean, and this was an improvement on our previous inspections.
- The manager responded quickly to our concerns in order to ensure the immediate safety of patients, and sent an action plan to us within four weeks of the inspection which stated that the provider had already completed the following actions in response to our concerns about the ward environment, and

lack of appropriate moving and handling training. They also immediately put into place revised protocols in relation to eating and drinking, falls management and assessment and the use of covert medications.

## Are services well-led?

This was a focused inspection in relation to concerns raised about Fairfax ward. Ratings have not been given for this inspection. We have written to the provider following the inspection to advise them of immediate actions they must take to ensure patients are cared for safely.

We found the following issues that the provider needs to improve:

- The governance systems in place had not ensured the delivery of safe and high quality care. Provider audits had not identified the issues in relation to the quality of restraint records. The service managers had not recognised the risks we identified during this inspection.
- The provider had not ensured that all staff were able to access the training required to carry out their role safely. However, the provider had arranged additional staff training in moving and handling people. This was not taking place until June 2018.
- The provider had taken some action in regards to reducing restrictive practices since our recommendations in previous reports regarding the reduction in the use of prone restraint. However, they had not ensured that this was embedded and understood by the staff team. They had not acted in regards to staff training in specific methods of restraint for older people with mental health problems. The provider was not following their own strategy in relation to the reduction of restrictive practice on this ward.
- The provider was teaching methods of restraint designed to cause pain to patients (pain compliance). Although staff told us they were not used on Fairfax ward, and we did not see evidence of their use in patient records we reviewed for the inspection, we were concerned that they continued to be taught to staff using restraint techniques. We will address this with the provider.
- The provider had not ensured that staff kept clear and detailed recordings about patients. When staff used restraint techniques they did not record why they had restrained patients, and what de-escalation techniques were used prior to the use of restraint. Staff did not record clear reasons why they had used prone restraint with patients which should only be used in exceptional circumstances.

# Summary of this inspection

- The provider had not ensured that staff submitted notifications to the Care Quality Commission and the local authority safeguarding team without delay.
- The provider did not ensure that staff had access to adequate guidance in relation to falls management.

However, we found the following areas of good practice:

- The provider had established governance systems which involved all relevant parties and will provide a forum for the ward to make and monitor improvements.

# Detailed findings from this inspection

## Mental Health Act responsibilities

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

During this focussed inspection, we did not review Fairfax ward's compliance with their Mental Health Act responsibilities.

## Mental Capacity Act and Deprivation of Liberty Safeguards

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

# Wards for older people with mental health problems

| | |
|---|---|
| Safe | |
| Well-led | |

## Are wards for older people with mental health problems safe?

**Safe and clean environment**

We checked the environment of the ward for assurance that it was safe and clean.

The ward had a 'T' shaped layout, which did not allow staff a clear line of sight to observe patients. Staff mitigated this risk by having one member of staff allocated to observe patients at intervals throughout the day and night.

All areas of the ward contained ligature points including; communal lounges, patient bedrooms and corridors (a ligature point is something that a patient intent on self-harm could use to tie something to in order to strangle themselves).

The service had completed a ligature audit of the ward in December 2016. This was to identify potential ligature points to staff to enable them to use risk assessments and observations to reduce risks. However, staff had not ensured that this risk assessment addressed all areas of concern. For example, we found that two communal lounges contained fixed blinds and televisions fixed to the walls with trailing wires, which staff had not included on the ligature risk assessment. The clinical manager told us that they had rectified this immediately following our inspection. The clinical manager also revised ligature maps to identify to staff where ligature points were located in order to enhance the knowledge and understanding of staff. We will follow this up at our next planned inspection of this service in February 2018.

Only male patients were admitted to the ward, which meant that it remained compliant with guidance contained in the Mental Health Act Code of Practice and guidance from the Department of Health on eliminating mixed sex accommodation.

The ward did not have a seclusion room.

We found that all areas of the ward were clean and tidy. We observed staff cleaning the ward throughout our visit. This was an improvement on our previous visits to the ward where we had concerns about cleanliness.

We reviewed the environmental safety of the ward because the provider told us that 18 patients had fallen on Fairfax ward between 1 September 2017 and 11 November 2017. Of these falls, eight were un-witnessed by staff. One patient had suffered a significant injury because of a fall.

Staff had not identified, assessed and mitigated environmental risks. This meant that patients had a higher risk of falling. The corridor floors, particularly outside the staff office, were uneven and contained several sunken and raised areas. In patient bedrooms, there were no handrails for patients to aid their mobility. Light switches were located at the opposite end of patient bedrooms to their beds, and no bedside lighting was available. Although the ward was designed to care for older people with functional and organic mental health problems there was little signage available to orientate patients. Staff had not identified these issues on the most recent environmental risk assessment completed in April 2017. The hospital manager had taken some action; they had identified the uneven flooring on 10 November 2017 and staff were undertaking repairs at the time of our inspection.

Within four weeks of the inspection, the provider sent us an action plan which stated that they had completed the following works in relation to our concerns about the environment:

- employed an external contractor to fix the flooring
- moved the location of patient beds to ensure light switches were accessible, and would install highlighted back plates to these.
- received an order of additional handrails and signage to install

Staff carried personal alarms, which they could use in an emergency. Patients had access to nurse call alarms in their bedrooms. However, in communal areas alarms were located away from patient seating areas meaning that they were unable to reach them and call for help in an

emergency. Staff mitigated this risk by the use of continual observation in main lounges but patients were not continually observed in the quiet lounges off the main corridor.

**Safe staffing**

The provider had a staffing matrix, which the ward manager used to estimate the number of staff required to work on the ward during the day and night. For a maximum number of patients (22) this stated that two registered nurses and six healthcare support workers were required plus additional staff for patients receiving one to one care. At night, this establishment level was two registered nurses and four healthcare support workers.

A full time ward manager, psychiatrist, occupational therapist, ward clerk, social worker, two activity workers and a service user involvement lead also supported the ward. The hospital employed a physical health nurse who attended the ward as required.

We reviewed staffing rotas from 4 September 2017 to 12 November 2017. Staffing levels met the agreed staffing establishment level for registered nurses other than on two occasions during day shifts when only one nurse was on duty instead of the planned two. Healthcare support worker shifts reached the established levels.

The ward manager was able to make staffing adjustments, and request additional staff as required. Bank and agency staff worked on the ward on all shifts. There were 39 occasions between 4 September 2017 and 12 November 2017 where the only nurse on duty was a temporary agency or bank staff. One third of the 18 falls incidents between September and November had occurred during shifts where the ward was below establishment levels for qualified nurses or when only agency and bank staff were managing the ward. The manager told us that temporary staff are familiar with the ward, and received the same level of training and that they always worked with permanent staff. Therefore risk was not increased, we will review this further at our next inspection of the service in February 2018.

During our inspection, we saw that qualified staff were available to patients in communal areas of the ward.

We did not review all areas of mandatory training during this focussed inspection. However, we requested information from the provider regarding staff training in; prevention and management of violence and aggression and moving and handling of patients as these were the topics we had concerns about.

The provider told us that staff undertook three levels of training in prevention and management of violence and aggression:

- initial teamwork and promoting safe and therapeutic services training
- prevention and management of violence and aggression training (including restraint techniques)
- refresher training (staff undertake every 12 months).

There were 36 members of staff required to complete the full training programme in the prevention and management of violence and aggression. Of the 36 staff;

- Eight had not completed the initial course.
- Five had not completed the personal safety course.
- Eight had not completed a refresher course within 12 months.
- Three staff had completed no training.

Of the six permanent registered staff employed by the ward, only two were up to date with their training in the prevention and management of violence and aggression. Our review of staffing rotas between September and November 2017 showed that there were eight incidents of the use of restraint techniques where the qualified staff on duty were not up to date with their training. Four of these incidents involved the use of prone restraint, which is a higher risk method requiring additionally competent staff.

When staff are not appropriately trained, there is a risk that they may cause harm to patients by using high risk or incorrect techniques. We had received concerns from stakeholders and from the carers of patients that patients had received bruises caused by restraint techniques undertaken by staff.

However, following the inspection the provider gave us updated data which showed that 95% of staff had since received training.

We reviewed the training package taught to staff by the provider. We found that all staff (including those working on Fairfax ward were trained in the same restraint technique. These techniques included prone (chest down) restraint and the use of pain compliance.

Pain compliance techniques are a method of staff applying pressure to certain parts of the body in order to reduce resistance during restraint. Staff told us that they did not use pain compliance techniques on Fairfax ward due to the vulnerabilities of the patient group. We reviewed all of the restraint records for all patients on the ward between 1 July 2017 and 9 November 2017 and staff had not recorded any use of pain compliance in these restraint episodes. However, staff recording of restraint was poor so we could not be entirely sure that records were accurate as they lacked significant details.

We were concerned that the provider continued to teach these techniques to all staff across the hospital regardless of which ward they worked within, and that staff were not trained in specific types of restraint for use with more frail patients. This was a recommendation at our inspection in July 2016 and the provider had not made changes to their training package. We will follow this concern up with the provider as this is a provider wide policy rather than one which is local to Cygnet Hospital Wyke.

We reviewed the staff training programme regarding the moving and handling of patients. These methods are usually taught to show staff correct methods in which to move and support patients' with reduced risk to patients and to staff. This was of high importance on Fairfax ward as patients had mobility difficulties.

Staff we spoke with, including the occupational therapist told us that they had not undertaken manual handling training other than electronic learning in relation to moving and handling equipment safely (boxes for example). The provider told us that staff should complete two levels of training, one an electronic training package in relation to general moving and handling of equipment and the other face to face moving and handling people training.

- Of 34 eligible staff including occupational therapists, 23 had completed the electronic learning programme (68%).
- Of 34 eligible staff including occupational therapists, only one had completed manual handling of people training.

We saw a direct impact of this during our visit when we witnessed a member of staff supporting a patient by holding their arm to pull them from a chair.

We were concerned about how untrained staff moved patients once they had fallen. Staff told us that they did not lift patients from the floor, but used the hoist. Other staff members told us that they never used the hoist because staff had not been trained and patients had not been assessed to use the hoist. Staff said that if a patient could not get up independently they would call an ambulance to help. We did not see evidence in patient notes that staff had called an ambulance after a patient had fallen.

We were concerned that occupational therapists who were responsible for assessing mobility needs and completing falls risk assessments had not received training in the moving and handling of people. This meant that they could not share their knowledge with other staff and ensure staff were aware of how to correctly support patients in care plans. The provider's own policy in relation to 'slips, trips and falls' (August 2016) states that "unit managers will ensure that all staff are provided with suitable information, instruction and training in relation to managing the risk of injury arising from slips, trips and falls. This will be delivered via induction, mandatory or bespoke training programme."

However, the provider had recognised this gap in knowledge prior to our inspection, and had planned training courses for staff in June 2018.

Within four weeks of our inspection the provider sent us an action plan to show us the actions they had completed to reduce the risk of falls to patients in response to our immediate concerns, this included:

- immediately putting into place a 'post fall assessment and management guide' for staff, which ensured all patients had a falls risk assessment in place within 12 hours of admission.
- the provider had given all staff hoist training and manual handling of people training was planned for 8 December 2017 with further dates for staff training in January 2018.

We will follow this up at our next planned inspection of this service in February 2018.

**Assessing and managing risk to patients and staff**

We asked the provider to show us data regarding the number of uses of restraint, which staff had undertaken with patients between 1 July 2017 and 9 November 2017 on Fairfax ward. There had been 322 incidents of restraint

within this 18 week period. The majority of restraint incidents had occurred when patients were resistive to personal care, or when patients had displayed violence and aggression to staff and other patients.

- In July there were 67 incidents involving the use of restraint involving six patients.
- August (95) with ten patients
- September (84) with 11 patients
- October (63) with 17 patients
- November (13) with 11 patients.

The service had a 'promoting safe and therapeutic services, the prevention and management of violence and aggression' policy (January 2017). The provider had reviewed this policy since the time of our last inspection in July 2016. At the time of this inspection, we told the provider that they should ensure staff working on Fairfax ward received physical intervention training, which was appropriate to the patient group. Staff told us that this training had not taken place. However the provider's policy stated that staff should take the following into account when working with older adults:

- Planned interventions will be developed with input from the service user and their family or carers.
- Specific care should be taken to address any physical problems that may be associated with, for older adults, 'the ageing process' such as arthritis, dislocation, decreased peripheral circulation, cardiovascular stress, muscle atrophy, thinking of the outer layer of the skin (epidermis), etc.
- Intentional use of prone and supine restraint should be avoided and staff must do all they can to manage the situation in a standing or seated position, except for in extreme circumstances where there is a risk of serious harm to others and the risk cannot be safely managed using a less restrictive option.
- Should the service user end up in a prone or supine position they are to be supported to a standing or seated position as soon as is practicable or released if safe to do so.

Staff did not record that they had followed the above areas of the policy to ensure they reduced the risk of harm. During the inspection, we reviewed the staff recordings in ten restraint episodes. We found that in none of these ten episodes had staff recorded what de-escalation techniques had been utilised prior to the use of restraint. This meant that we could not be sure that the use of restraint was proportionate to the risk presented by the patient.

Staff had undertaken the majority of restraint in order to complete personal care tasks with patients who were resistive. This meant that staff were managing infection risks. However, we found that staff did not use techniques such as positive behavioural support planning. These methods are used with patients with challenging behaviours to reduce incidents of aggression and challenge and reduce the need for physical intervention with patients.

We reviewed the care plans of three patients who staff had restrained more than 25 times each between 7 September 2017 and 6 November 2017. Staff told us that this was because these patients required restraint to allow staff to complete personal care tasks. For two of the three patients, the care plans contained little or no information about why patients were resistive to personal care and what processes had been attempted to reduce the risk of restraint and de-sensitise the patient to these processes. Care plans were not personal to the patient and contained generic and nonspecific statements, they did not include the voice of the patient or their carer/relatives in discussing the techniques or reasons for the resistance.

Of these restraints 15 had been undertaken in the prone (chest down) position between 1 July 2017 and 9 November 2017. National Institute for Health and Care Excellence guidance (NG10) recommends avoiding prone restraint, and only using it for the shortest time possible. The Mental Health Act Code of Practice states that "unless there are cogent reasons for doing do, there must be no planned or intentional restraint of a person in a prone position. This is because there is an increased risk of patient asphyxiation when this method is used. This risk is increased for frail patients and those with associated physical health conditions, such as the patients admitted to Fairfax ward. We reviewed one incident where staff moved the patient into a chest down seated position whilst they were seated by staff. The incident noted that the patient 'turned purple'. This was not investigated as a serious incident to allow learning to be shared with staff and impact on changes to practice. At our inspection in June 2015, we told the provider that they must introduce measures to reduce the use of prone restraint by staff. In

response to our immediate concerns, the provider told us that their lead on the prevention of management of violence and aggression would undertake an investigation into this incident and notify us of their findings.

We reviewed staff recordings of prone restraint and found that staff recording was poor. Records did not state why staff had used prone restraint with the patient or what de-escalation techniques staff had undertaken in attempts to avoid its use or to use it as a last resort. One record simply stated 'patient put to the floor'. This meant that it was not possible to assess whether the use of restraint was proportionate to the risk presented.

We reviewed the management of medications to ascertain whether this was contributing to the injuries suffered by patients. Medication administration cards were in good order and staff had not prescribed high dose antipsychotic medication to patients. However, we did have a number of concerns regarding the management of medication.

One patient had insulin dependent diabetes and was prescribed and administered daily insulin doses. Staff had not undertaken blood glucose monitoring with this patient for the five days prior to our inspection. The clinical manager agreed to rectify this immediately after our inspection.

We found that two other patients had care plans in place for their medications to be given covertly. Covert medication is the administration of any medical treatment in a disguised form. This usually involved disguising medication in food or drink. As a result, the patient is unknowingly taking medication. The care plans for these patients were not adequate. They did not explain which medications could be crushed and what food or drink they should be given with. There was no evidence that discussions had taken place with a pharmacist to ensure medication was safe to use in this manner. The clinical manager agreed to rectify this immediately after our visit and has since provided us with a revised protocol, which the ward staff now follow.

There had been 18 patient falls on the ward between 1 September 2017 and 11 November 2017. Staff were not taking preventative action to reduce the risk of falls and not adequately assessing patient's mobility needs. A number of patients had been admitted to the ward with conditions, which meant that they had a high risk of falling such as long term medical conditions, an unsteady gait, poor vision and previous falls. Despite this information, staff had not undertaken a falls or mobility assessment with patients in line with the provider's own policy. The 'prevention and management of slips, trips and falls' policy (August 2016) stated, "for those service users at significant risk of falling, ward managers should ensure that an appropriate plan of care has been formulated and implemented".

We saw evidence that this lack of assessment had contributed to patients coming to harm on the ward. In the records of one patient staff had observed them to be 'rolling around in their bed' several times, the member of staff did not act until the patient then fell from their bed. One patient, who suffered a significant injury following a fall, had two previous falls while admitted to the ward. Despite this, and staff noting a moderate falls risk within the patient's generic risk assessment, no mobility or falls assessment was undertaken to reduce risk and preventative action was taken to reduce the impact of falls such as by the use of hip protectors. Since the time of the inspection, in response to our feedback the clinical manager has created an implemented, a new falls protocol for use by all staff.

During the inspection, we observed patients having lunch in the dining room. There were no protocols in place to manage risks for patients at risk of choking while eating and drinking due to their medical conditions. The clinical lead agreed to rectify this immediately after our inspection and has since provided a revised protocol.

Staff did not always make referrals to the local authority and the Care Quality Commission when safeguarding incidents occurred on the ward. Between 15 October 2017 and 6 November 2017, there were four incidents where patients caused harm or injury to other patients. Only one of these incidents was reported to the local authority safeguarding team and the Care Quality Commission. Staff told us that they did not think referrals were required, as patients had not sustained injuries. This meant that staff did not understand the requirements to consistently and appropriately report safeguarding concerns to the local authority.

Since the time of the inspection, service managers have met with the local authority safeguarding team to improve reporting, learning, and working together.

# Wards for older people with mental health problems

## Are wards for older people with mental health problems well-led?

There were a number of issues we found during this inspection which meant that the governance structures for the ward were not always effective and did not ensure patient safety.

The provider had not ensured that all staff were trained in techniques to ensure they could perform their role safely with a reduced risk of harm to patients. Not all staff were trained in the prevention and management of violence and aggression or in moving and handling people.

The provider had not ensured that suitably skilled, qualified and experienced staff were available on all shifts.

The provider had a reducing restrictive practice strategy and delivery plan in place which states that Cygnet Health care "is committed to reducing the use of restrictive practice in all clinical settings". The provider had not acted upon our recommendations in previous reports regarding the reduction in the use of prone restraint. They had not acted in regards to staff training in specific methods of restraint for older people with mental health problems.

Records of restraint lacked the required detail to evidence the use of de-escalation and the reasons for the use of restraint, particularly in relation to the use of prone restraint. Provider audits had not identified the issues in relation to the quality of restraint records. This meant that managers could not be assured that when restraint was undertaken it was proportionate and in line with the Mental Health Act Code of Practice.

The provider had not ensured that staff submitted notifications to the Care Quality Commission and the local safeguarding team without delay. This is a requirement of their registration requirements.

The service managers had not recognised the risks we identified during this inspection. There was no evidence that staff had met to discuss risks and find an appropriate solution to the number of falls and the high use of restraint on the ward. We reviewed the last three integrated governance meetings and saw no notes of concern raised by managers. However, the medical director had recognised staffing concerns on Fairfax ward in July 2017 and had requested action be taken to reduce risk.

The providers slips, trips and falls policy was not adequate. This was because it did not provide staff with detail of when and how mobility assessments should be carried out, or what constitutes a significant falls risk.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that staff undertake care planning and risk assessments, which include the entirety of patient's needs and ensure that actions are taken when risk is identified.
- The provider must ensure that all ligature risks are assessed, monitored and removed or mitigated.
- The provider must ensure that the ward environment is safe and fit for use.
- The provider must ensure that medicines are managed safely and as prescribed.
- The provider must ensure that staff are appropriately trained in prevention and management of violence and aggression and the moving and handling of patients.
- The provider must ensure that the systems in process in place adequately monitor incidents such as restraint and falls and that action is taken when risks are identified.
- The provider must ensure that staff are trained in appropriate uses of restraint with older patients.
- The provider must ensure that staff make accurate and contemporaneous records about patients particularly in episodes of restraint.
- The provider must ensure that staff report all safeguarding concerns to the local authority and the Care Quality Commission.
- The provider must ensure that there is a defined protocol and individual care plans in place to manage the needs of patients who need support with eating and drinking.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>**How the regulation was not being met:**<br><br>**Care and treatment was not provided in a safe way for patients because staff were not regularly assessing the risks to the health and safety of patients and doing all that was practicable to remove or mitigate those risks in relation to ligature risk assessments, environmental audits and a lack of falls and mobility risk assessments for patients.**<br><br>**The provider did not ensure that all persons providing care had the necessary skills and competence to do so. Staff were not trained in moving and handling patients and not all staff had adequate training in prevention and management of violence and aggression. The provider had trained staff in the use of restraint which is inappropriate with older, frail patients.**<br><br>The provider did not ensure that the premises used were safe to use and fit for their intended purpose. The ward was not safe because of a lack of appropriate equipment, signage and flooring.<br><br>The provider did not ensure the proper and safe management of medicines.<br><br>**This was a breach of regulation 12 (1) (a) (b) (c) (d) (g)** |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>**How the regulation was not being met:** |

This section is primarily information for the provider

# Requirement notices

The provider had not ensured that systems or processes were established and operated effectively to ensure compliance with the requirements and that they could assess, monitor and mitigate the risks relating to the health, safety and welfare of patients because they were not aware of the concerns we identified during the inspection and the risks these concerns presented to patients.

The provider did not ensure that an accurate and contemporaneous record was kept in respect of each patient. Including the decisions taken in relation to their care and treatment when methods of physical intervention were used such as prone restraint to record why the use of this was proportionate and that it was only used in exceptional circumstances.

**This was a breach of regulation 17 (1) (2)**

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents<br><br>**How the regulation was not being met:**<br><br>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.<br><br>**This was a breach of regulation 18 (1) (2) (e)** |