Cygnet Chesterholme

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Inadequate

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

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Ted Baker
Chief Inspector of Hospitals

Overall summary

We rated Cygnet Chesterholme as inadequate because:

- Our findings from our key questions did not demonstrate that governance processes operated effectively at ward level and that risks were managed well. The provider had not ensured that there was sufficient oversight of governance processes. During our inspection, there were some issues that we identified with governance which were not picked up by the provider.
- The provider's governance systems were not always sufficiently assessing, managing and mitigating risks for the patient. Risk assessments were not consistently updated and reviewed following incidents or changes to a patient's presentation or increased use of medication.
- Information identified within risk and care plans, such as how patients should be restrained if this was required (e.g. patient at risk of positional asphyxia due to obesity) was not evident within positive behaviour support (PBS) plans. PBS plans were generic and did not refer to information captured elsewhere that was specific to the patient and their likes/dislikes.
- The provider's systems for ensuring staff recorded their handover of patients' epilepsy monitors was not robust as we found gaps in records.
- The Resuscitation Council UK quality standards for cardiopulmonary resuscitation practice and training state that the provider should have the equipment and medication to manage medical emergencies arising from rapid tranquilisation. The hospital did not hold a supply of medicines for emergency use and had not completed a risk assessment to demonstrate the rationale for this decision at the time of inspection.
- The provider did not have the correct paperwork within the individual agency staff personnel folders to show that thorough checks had been made. These documents were subsequently located and filed appropriately.
- Although the hospital had been taken over by Cygnet in 2018, there was confusion amongst staff about which policies procedures and paperwork they should be using. Two of the provider's policies that staff were following were still those of the previous organisation that managed the hospital (Danshell) and were overdue for review. Staff did not know whether they should be following Cygnet's vision and values or those from the previous provider Danshell.
- Staff recruitment and retention at the hospital was not always effective.
- Staff did not have the necessary skills and knowledge to work with patients who had a learning disability or autism.

However:

- Patients were receiving structured and consistent activities to undertake, including at the weekends.
- Staff interactions we observed were mostly positive.

Summary of findings

- Notifications to the care quality commission were now being submitted correctly.
- We received positive feedback from carers we spoke to.
- An informal patient now had a key fob to allow them to leave the building without delay.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Inadequate 	

Summary of findings

Contents

Inadequate

Cygnet Chesterholme

Services we looked at
Wards for people with learning disabilities or autism

Summary of this inspection

Background to Cygnet Chesterholme

Chesterholme is an independent hospital located in Hexham, which provides care and treatment for up to 26 patients with a diagnosed learning disability or autism. There were 10 patients at the hospital at the time of the inspection. Chesterholme is part of the Cygnet Group.

The service has been registered with the CQC since September 2013. It was taken over by Cygnet healthcare in 2018 (it had previously been managed by Danshell) and is registered to provide the following regulated activities:

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

The service had a registered manager. There was an accountable officer in post.

Chesterholme is a two-storey unit which provides accommodation for both male and female patients.

A comprehensive inspection was carried out on the 13 and 14 November 2018 and this service was rated as requires improvement overall. We rated the key question of responsive and caring as good and safe, effective and well led as requires improvement.

Our inspection team

The team that inspected the service comprised one inspection manager, three inspectors, a pharmacy inspector and one specialist advisor who was a nurse. The team members attended the service on different days.

This unannounced inspection was carried out at very short notice, which meant that we had insufficient time to make a request for an expert by experience on this inspection.

Why we carried out this inspection

We inspected this service following specific and significant concerns received about the safety and culture within the other services managed by the provider in that region. During our inspection, we identified additional concerns. These additional concerns were significant enough that on the 16 May 2019, we extended our focused inspection to a comprehensive inspection.

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?

Because this was a responsive inspection we did not have routine information to review before this inspection.

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- undertook four Short Observational Framework of Inspections structured observations
- spoke with five patients
- spoke with the registered manager and deputy manager for the unit

Summary of this inspection

- spoke with eight other staff members including doctors, nurses, assistant psychologist and assistant speech and language therapy assistant, the administrative support and the catering staff
- attended and observed one multi-disciplinary meeting
- attended two flash meetings
- looked at six care and treatment records of patients
- carried out a specific check of the medication management on the unit and reviewed nine prescription cards and associated paperwork
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us that the food was good, and they enjoyed going for walks and going shopping into Hexham.

They told us staff were good and they liked them, and that staff encouraged them to tell them when things were wrong, so they could help them sort it.

Carers reported that staff were very good. When they visited, they saw good examples of support workers being supportive of their relative even during episodes of aggression

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?

Inadequate 

We rated safe as inadequate because:

- There had been a significant increase in the use of restraint since our previous inspection. Despite this, positive behaviour support plans lacked sufficient detail to guide staff. Staff were not updating risk assessments or positive behaviour support plans following incidents.
- The hospital did not stock emergency medicines required should rapid tranquilisation be used and at the time of the inspection the provider had not completed a risk assessment to demonstrate the rationale for this decision.
- Staff, who were involved in using physical restraint and in supporting patients who were administered rapid tranquilisation, were not trained to immediate life support level.
- Two of the provider's policies that staff were following were still Danshell policies and were overdue for review.
- The provider's systems for ensuring that staff recorded their handover of patients' epilepsy monitors was not robust as we found gaps in records.
- The turnover rate of staff was high at 45%, and there had not been sufficient management of recruitment of staff.
- The manager told us that agency and bank staff received induction, but they were initially unable to locate all records confirming that this had occurred. These were subsequently located and filed appropriately.
- Managers could not initially locate records confirming all agency staff had disclosure and barring service checks in place. These were subsequently located and filed appropriately.
- Managers could not initially locate records confirming that all agency staff had attended conflict resolution training. These were subsequently located and filed appropriately.

However:

- There was no evidence of blanket restrictions being applied to patients.
- The hospital's staff participated in the provider's restrictive interventions reduction programme.
- In each lounge there was a shred box so when patients were feeling upset or frustrated they could utilise this instead of self-injurious behaviours.

Summary of this inspection

- Ninety one percent of staff were up to date with essential training.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Not all staff were suitably qualified in learning disability and autism and had the correct skills to meet the needs of the patient group.
- Staff were not trained in epilepsy or had received refresher training if needed.
- There was not any Makaton training available to staff at the time of the inspection despite many patients using this communication method.

However

- Staff followed best practice when storing, administering, and recording the use of medicines.
- Staff assessed the nutritional needs of the patients and we saw examples of staff making sure that food provided was suitable.
- Ninety-one percent of staff had received an appraisal in the last 12 months leading up to the inspection.
- While the door to the unit was locked, informal patients were issued with a door fob and could leave and re-enter the building as needed.

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Are services caring?

Good

We rated caring as good because:

- Staff were ensuring that patients were offered and were able to attend planned activities, including those out in the community.
- We also observed joint activities between the patients and staff. Patients were observed to have their own music on in their respective bedrooms and lounges. There was a female only lounge as well as enough communal space for patients to relax in.
- Staff involved patients in the development of their care plans and risk assessments. Care plans showed evidence of patients signing their care plans, which were available in easy read formats.
- Carers reported good examples of nursing staff being supportive of their relative.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- Discharge planning started on admission to the service and we observed discussions around discharge taking place within the multi-disciplinary team meeting. Staff planned for these discharges.
- The service was accessible to all who needed it and took account of patients' individual needs. Staff helped patients with communication, advocacy and cultural support.
- There were many examples of easy read and pictorial care plans, including 'my meeting feedback', 'my care plan', 'my day care plan, epilepsy care plans and activity plans.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- Staff were not trained in epilepsy or Makaton

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- Our findings from the other key questions did not demonstrate that governance processes operated effectively at ward level and that risks were managed well. The provider had not ensured that there was sufficient oversight of governance processes. During our inspection, there were some issues that we identified with governance which were not picked up by the provider.
- The provider's governance systems were not always sufficiently assessing, managing and mitigating risks for the patient. Risk assessments were not consistently updated and reviewed following incidents, changes to a patient's presentation or increased use of medication.
- The provider had not initially made thorough checks to ensure agency staff had the correct paperwork in place in their personnel folder. However these were found and filed correctly.
- Two of the provider's policies were out of date since 2017.
- Although the hospital had been taken over by Cygnet in 2018, there was confusion amongst staff about which policies procedures and paperwork they should be using.
- Staff did not know which vision and values they should be following, Cygnet or Danshell's

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.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. All relevant Mental Health Act paperwork was stored in a paper-based file kept securely in the main office.

Mental Health Act training was mandatory for qualified staff and 100% of these staff were trained.

CQC completed a Mental Health Act monitoring visit in December 2018 and there were two actions around section132 (discussion of patient rights) and section17 (patient leave from the unit).

When we reviewed Mental Health Act documentation at this inspection, it was evident that staff were now regularly informing patients detained under the Mental Health Act of their rights, using easy read formats where needed, and recording patient's understanding of this.

There was a process for allowing section 17 leave, and we observed staff checking leave permissions, discussing with the nurse in charge and a risk assessment being undertaken as well as documented record of this leave. All old section 17 leave forms were scored through and removed from current notes for archiving.

Staff requested a second opinion appointed doctor when required. All detained patients' records contained capacity to consent to treatment assessment and all records contained a T3 certificate. A T3 certificate is issued by a second opinion appointed doctor appointed by the CQC where a detained patient cannot or will not consent to treatment. For one patient, medicines were prescribed which were not included on the relevant certificate. We discussed this with the responsible clinician who took immediate action to ensure valid consent to treatment documentation was put in place. We saw evidence that treatment was regularly reviewed, for example Section 61 review of treatment forms.

While the door to the unit was locked, all informal patients were issued with a door fob and could leave and re-enter the building as needed.

Every six months the nursing staff undertook audits around the use of the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

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

Mental Capacity Act training was mandatory for all staff and 88% of staff were trained; this included Deprivation of Liberty Safeguards.

There were three Deprivation of Liberty Safeguards applications and authorisations made in the 12 months leading up to our inspection to protect people without capacity to make decisions about their own care. This was in line with the number of patients who were subject to Deprivation of Liberty Safeguards that the provider had reported to us at the time of our inspection at the hospital.

When patients lacked capacity to make decisions on specific issues, they were able to involve advocacy or family if they were involved in their relative's care. We found paperwork relating to the Mental Capacity Act to be correct and in line with the provider's policy.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

Notes

Inadequate

Wards for people with learning disabilities or autism

Safe	Inadequate
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Inadequate

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

The unit was safe, clean, well equipped, well furnished, well maintained and fit for purpose. Cleaning records were up to date and completed daily. Staff did regular risk assessments of the care environment. There was evidence that the fire alarms, fire extinguishers, emergency lighting and door closers and sensors had all been checked recently and on an ongoing basis. While staff could not clearly see all areas of the ward, a full ligature risk assessment had been completed and all patients had enhanced observations if required to mitigate any risks. Staff knew about any ligature anchor points and actions to mitigate risks to patients who might try to harm themselves.

The ward was mixed sex, however had separate male and female bedrooms. All had access to their own shower facilities and there was a separate female lounge.

Staff had easy access to alarms and patients could access nurse call systems. There was evidence that these were checked monthly.

The clinic room was fully equipped, and the ward had resuscitation equipment. However, the medicines policy stated all medical emergencies should be dealt with by the appropriate primary care or acute service. The Resuscitation Council UK quality standards for cardiopulmonary resuscitation practice and training state that the provider should have the equipment and medication to manage medical emergencies arising from rapid tranquilisation, however the hospital did not hold a supply of medicines for emergency use and no risk assessment had been completed to demonstrate the rationale for this decision at the time of the inspection.

Staff maintained the equipment in the clinic and we could see that regular checks were being done. Fridge temperatures were recorded daily, and all were in range.

Safe staffing

Staff recruitment and retention at the hospital was not always effective. The staffing establishment for Chesterholme was six qualified nurses and 49 support workers. At the time of the inspection they had five qualified nurses and only 25 support workers who had permanent contracts. At the time of the inspection the hospital had a 45% staff turnover rate. At our last inspection, we were concerned about the number of staff available on each shift. But on this inspection, reviewing the staffing rotas and bank usage since December 2018, we could see that there had only been three shifts that had not been covered by bank or agency staff. However we found that there was an increasingly high number of unqualified and untrained staff working with this complex patient group.

Managers had calculated the number and grades of staff required, which included nurses and healthcare assistants. There were enough staff on duty to safely carry out conflict management (MAYBO) and in the 12 months leading up to our inspection, there was no escorted leave cancelled due to staff shortages.

The provider's standard was to have one qualified nurse on duty and 15 support workers during the day and one qualified nurse at night and seven support workers.

The nurse in charge in discussion with the registered manager could adjust staffing levels daily to take account of patients' presentations.

When agency and bank nursing staff were used, managers told us that those staff received an induction to the services, were DBS checked, were trained in physical interventions and were familiar with the ward. However, on checking this the ward were initially unable to locate the DBS checks, record of conflict management training (MAYBO) or confirm that three staff had received a local induction in the agency staff's personnel files. This was rectified during the inspection by the registered manager, who located these documents and filed them correctly in staff files.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward within 20 minutes in an emergency. There was one consultant psychiatrist in post, he also worked at another service for part of the working week.

Mandatory training

The service provided mandatory training in key skills to all staff. Overall, staff in this service had undertaken 91% of the various elements of training that the provider had set as mandatory.

Training course

Percentage

Emergency first aid 95%

Maybo 97%

Fire safety 86%

Safeguarding adults 95%

Infection control 84%

Medication management (qualified staff only) 85%

Equality and Diversity 93%

Data protection 90%

Food safety 90%

Health and safety 97%

Lifting and handling 91%

Total overall 91%

Assessing and managing risk to patients and staff

During inspection we reviewed six patient care records and found that in four of them, risk assessments were not consistently updated and reviewed following incidents. They were reviewed as a generic review, rather than in response to an incident or change in presentation. We could not see evidence of how particular risks were to be managed or mitigated. For example, a patient deemed at 'high risk' of falls did not have a specific falls care plan in place and it was unclear how staff planned to mitigate the risk in any other way.

We also found that an 'as required' medication care plan had been regularly reviewed but no changes had been made to the patient's care and treatment despite high use of additional medication over a three-week period.

Management of patient risk

Positive behaviour support plans were in place for all patients and a positive behaviour support grab sheet was available. However, information identified within risk and care plans, such as how patients should be restrained if this was required (for example a patient at risk of positional asphyxia due to obesity) was not evident within positive behaviour support plans. Positive behaviour support plans were generic and did not refer to information captured elsewhere that was specific to the patient and their likes or dislikes.

The unit's staff participated in the provider's restrictive interventions reduction programme. However, the data show that the number of reported uses of restrain had increased considerably.

Blanket restrictions

There was no evidence of blanket restrictions applied to patients, for example they could make drinks freely, go in to the garden, all bedrooms were open for free access, bedrooms were personalised, and patients had choice around their daytime activities.

The unit had one patient who was informal, and they were allocated their own fob, which allowed them easy access in and out of the building but did not allow them access to non-patient areas.

Patients could smoke in a designated smoking area.

Use of restrictive interventions

The provider reported that they did not use seclusion and there had been no incidents of long-term segregation. The provider ensured that all bank and agency staff were fully trained in conflict management training (MAYBO) before they could work with patients.

The hospitals staff participated in the provider's restrictive interventions reduction programme.

The aims of this strategy included a reduction in self injurious behaviour, violence and aggression to others and the environment as well as a reduction in the need for physical interventions. It also included shortening the length of stay, enhancing service user and family engagement and promoting a positive safety culture.

In keeping with the restrictive intervention's reduction programme, all patients were provided with a 12 week multi-disciplinary team assessment process and positive behaviour support plans and all staff received training on positive behaviour support and de-escalation.

Multi-disciplinary meetings were held monthly to help formulate and devise new strategies for the individual to help with a reduction in the number of incidents and restraints.

In each lounge there was a shred box so when patients were feeling upset or frustrated, they could utilise this instead of self-injurious behaviours. There were also plans to have calming boxes located in each lounge where patients would be able to utilise different exercise techniques and soft items to squeeze.

Despite the provider participating in a restrictive intervention programme we found that between April 2018 and May 2019 there had been 581 incidents of restraint. Of those 194 were floor-based holds and 387 non-floor-based holds. There were no episodes of prone (face down) restraint.

At our last inspection we found that there were 124 restraints in a six-month period, and in our 2015 inspection there were 22 restraints in six months. These figures show an increasing number of restraints between inspections.

Safeguarding

Both qualified and unqualified staff knew 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, 95% of staff were trained. Staff told us they would report all safeguarding concerns. Visits for children occurred in a room just outside the main hospital.

Notifications had been submitted to the local safeguarding authority when required. In our previous inspection we issued a requirement notice as we found that the hospital was not submitting all the required notifications and some that were submitted were incomplete or contained incorrect information. This action was now corrected, and the hospital manager and regional manager now had oversight over this area and there had been no further incidents of this.

Staff access to essential information

All patient information at Chesterholme was kept in paper files except for the online incident recording system. Staff kept detailed records of patients' care and treatment. Records were clear and easily available to all staff providing care, this included MDT paperwork, MHA paperwork and contemporaneous records. We did find that whilst this information was there and available, not all of it was being updated adequately following incidents or changes to patients presentation.

The online incident recording system allowed access for registered nurses and senior healthcare assistants, this included agency registered nurses. When viewing incidents, we could see that an agency nurse had completed some of these incident reports.

Medicines management

Medicines management was supported by a range of policies, however the medicines management policy and the rapid tranquilisation policy that staff were still using were Danshell policies and were overdue for review since November 2017.

We reviewed one episode where a patient had been given rapid tranquilisation (this is where an injection is given to quickly calm an agitated patient) we found that all observations had been recorded in accordance with national guidance and the hospital policy. However, the medicines policy stated all medical emergencies should be dealt with by the appropriate primary care or acute service, and the hospital did not hold a supply of medicines for emergency use. No risk assessment had been completed to

demonstrate the rationale for this decision. If undertaking rapid tranquilisation staff should be trained to immediate life support level and we found that staff at Chesterholme had only been trained to basic life support level.

We reviewed nine medicines charts and patient records in detail and found staff kept accurate records of the treatment that patients received. Prescriptions for medicines to be given as or when required contained enough information to enable nurses to administer them safely.

We reviewed consent to treatment documentation and found medicines were mostly prescribed in accordance with the provisions of the Mental Health Act. For one patient, medicines were prescribed which were not included on the relevant certificate. We discussed this with the responsible clinician who took immediate action to ensure valid consent to treatment documentation was put in place. We saw evidence that treatment was regularly reviewed, including completed Section 61 review of treatment forms.

We checked physical health monitoring for six patients who were prescribed antipsychotic medicines. Blood tests, except for prolactin levels, ECGs and physical observations were carried out in accordance with national guidance and best practice recommendations, and a record was kept in the MDT file for each patient. One patient was prescribed a medicine which required regular monitoring of blood levels to ensure the treatment was safe and effective. We saw this monitoring had been completed at the appropriate intervals, and the results were recorded in the patient's MDT file.

The hospital had a policy of observing patients every 15 minutes for two hours when they had received oral medicines to calm or sedate them and recording the outcome on a 'PRN medication efficacy form'. We found that staff did not always record the effectiveness of these medicines once they had been administered in accordance with the policy.

Track record on safety

The number of serious incidents in the last 12 months leading up to the inspection was 27. The provider did not give us a breakdown of the nature of these incidents.

Reporting incidents and learning from when things go wrong

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

The hospital had a clinical governance meeting every month, this meeting looked in detail at incident trends, serious untoward incidents, whistleblowing, safeguarding referrals and regulatory notifications.

Root cause analyses were also discussed at this meeting and any outcomes of investigations. These incidents were also cascaded down to frontline nursing staff via their local team meetings and Mental Health Act monitoring visits and associated action plans were discussed.

In our previous inspection we issued a requirement notice as we found that the hospital was not submitting all the required notifications to the CQC and some that were submitted were incomplete or contained incorrect information. This action was now corrected, and the hospital manager and regional manager now had oversight over this area and there had been no further incidents of this.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, and these were reviewed regularly by multi-disciplinary discussion.

Generally, care plans reflected the needs of the patients and were personalised. On two records physical health checks were completed on admission which included weight, height, BMI, temperature and saturations. A dental appointment and opticians' appointment were also offered, and a risk/fall assessment was undertaken as well as a pressure ulcer assessment. We did however find that in some records, while an initial assessment and care plans

were undertaken, these did not always translate in to care plans and risk management plans and the reviews of these were not being undertaken when patients' presentation changed.

Best practice in treatment and care

Positive behaviour support plans were in place for all patients and a positive behaviour support grab sheet was available. However, information identified within risk and care plans, such as how patients should be restrained if this was required (for example a patient at risk of positional asphyxia due to obesity) was not evident within positive behaviour support plans. Positive behaviour support plans were generic and did not refer to information captured elsewhere that was specific to the patient and their likes or dislikes.

Staff followed best practice when storing, administering, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health. They were aware of, and worked towards achieving the aims of, the national STOMP programme (stop over-medicating people with a learning disability).

Staff assessed the nutritional needs of the patients and we saw examples of staff making sure that food provided was suitable, for example we saw that the chef was working closely with the assistant speech and language therapist to ensure that food provided was suitable for those with dysphasia. We did however observe that staff were not accurate in their recording of what a patient had eaten who had a low BMI, we reviewed food charts, and these were not regularly completed. There was no indication of what staff should do if meals were not consumed. A malnutrition universal screening tool had been completed which identified patients at 'high risk' but no further actions or plans around this. A patient was observed to only eat a couple bites of a sandwich, when their file was checked it said they had eaten their food. This meant that staff may not always be aware that a patient had consumed all of their food.

Staff had used rapid tranquilisation eleven times in the 12 months leading up to the inspection. The Resuscitation council UK Quality standards for cardiopulmonary resuscitation practice and training state that if staff undertake rapid tranquilisation they should be trained to immediate life support standard and no one was. We found that the staff on the unit were only trained in emergency first aid which was the equivalent of basic life support.

Skilled staff to deliver care

The provider's standard was to have one qualified nurse on duty and 15 support workers during the day and one qualified nurse at night and seven support workers.

All substantive staff received an induction to the service as well as training to enable them to carry out their role. This induction consisted of learning disabilities awareness, introduction to autism, introduction to PBS, conflict management training (MAYBO), person centred approach, company mission and values and also gave staff further reading. This very basic training on learning disability awareness was only available to permanent staff and not agency staff so would not have given the unqualified staff agency or bank staff the necessary skills and knowledge to assist them to look after this complex patient group.

The unit had access to a speech and language therapist, a consultant psychologist, a consultant psychiatrist and art therapist. At the time of the inspection the occupational therapist was away from work but the service had access to and utilised an occupational therapist from a neighbouring service as required. The unit ran on high levels of unqualified agency and bank staff and it was not clear what training these staff had on learning disability and autism.

Managers supported staff with appraisals, supervision, opportunities to update and further develop their skills. Ninety-six percent of staff had received supervision and 91% of staff had received an appraisal in the last 12 months leading up to the inspection.

Staff were previously trained in epilepsy and the responsible clinician had a special interest in this area, however this training had not been formalised for nursing staff or included refresher updates. Given the high turnover of staff at 45%, it was not clear how the provider was assuring itself that staff had this essential training for working with patients who had epilepsy.

There wasn't any Makaton training available to staff at the time of the inspection despite many patients using this communication method. Whilst the assistant speech and language therapist had developed communication plans

with patients who used their own signs of Makaton and did 'sign of the week' to encourage staff to learn on an ongoing basis, this could not be substituted for formal Makaton training.

All staff were offered extra training in reducing restrictive practice, service user specific workshops, face to face Mental Capacity Act and best interest, and sensory workshops. This was detailed in a staff training day.

Managers dealt with poor staff performance promptly and the registered manager was able to share some examples with us.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients, including, the activity coordinator, responsible clinician and the assistant speech and language therapist. They held regular multi-disciplinary team meetings where they discussed patients' progress. These meetings were structured and there was a full report produced for each patient, and the different sections were discussed by the different disciplines. These discussions included physical health monitoring, diagnosis, incidents, medication, PRN, sleep, mood, activities undertaken, observation levels, previous medical history and discharge pathway.

Staff shared information about patients at handover meetings every morning and evening. In addition to this, there was a flash meeting every morning, which included the attendance of the maintenance workers, catering staff, activity co-ordinator and nursing staff. These flash meetings were to plan an effective day for all the patients. There was a set agenda and was a recent addition to the hospitals governance structure and was evolving.

Staff supported staff to attend other health related appointments, such as GPs, opticians and dentist.

Adherence to the MHA and the MHA Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. All relevant Mental Health Act paperwork was stored in a paper-based file kept securely in the main office.

Mental Health Act training was mandatory for qualified staff and 100% of these staff were trained.

CQC completed a Mental Health Act monitoring visit in December 2018 and there were two actions around section132 (discussion of patient rights) and section17 (patient leave from the unit).

When we reviewed Mental Health Act documentation at this inspection, it was evident that staff were now regularly discussing with patients their rights if they were detained under the Mental Health Act their rights, using easy read formats where appropriate, and recording their understanding of this.

There was a process for allowing section 17 leave, and we observed staff checking leave permissions, discussing with the nurse in charge and a risk assessment being undertaken as well as documented record of this leave. All old section 17 leave forms were scored through and removed from current notes for archiving.

Staff requested a second opinion appointed doctor when required. All detained patients' records contained capacity to consent to treatment assessment and all records contained a T3 certificate. A T3 certificate is issued by a second opinion appointed doctor appointed by the CQC where a detained patient lacks capacity to consent to treatment or refuses to consent. For one patient, medicines were prescribed which were not included on the relevant certificate. We discussed this with the responsible clinician who took immediate action to ensure valid consent to treatment documentation was put in place. We saw evidence that treatment was regularly reviewed, for example Section 61 review of treatment forms.

While the door to the unit was locked, all informal patients were issued with a door fob and could leave and re-enter the building as needed.

Every six months the nursing staff undertook audits around the use of the Mental Health Act.

Good practice in applying the MCA

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

Mental Capacity Act training was mandatory for all staff and 88% of staff were trained; this included Deprivation of Liberty Safeguards.

Inadequate

Wards for people with learning disabilities or autism

There were three Deprivation of Liberty Safeguards applications and authorisations made in the 12 months leading up to our inspection to protect people without capacity to make decisions about their own care. This was in line with the number of patients who were subject to Deprivation of Liberty Safeguards that the provider had reported to us at the time of our inspection at the hospital.

When patients lacked capacity to make decisions on specific issues, they were able to involve advocacy or family if they were involved in their relative's care. We found paperwork relating to the Mental Capacity Act to be correct and in line with the provider's policy.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, privacy, dignity, respect, compassion and support

During our inspection we undertook observations of patient and staff interactions and four SOFIs (short observational framework for inspection). We also spoke with five patients.

Staff interactions that we observed were mostly positive and we saw good examples of staff interacting with patients and meeting their needs. We observed a couple of incidents where staff offered minimal interactions, but generally staff engagement with patients was good. There were a couple of occasions where patients had initiated hugging from staff and we observed one incident where a member of staff was stroking a patient's arm, this was discussed with the registered manager to review the boundaries between patients and staff.

Staff were ensuring that patients were offered and were able to attend planned activities, including those out in to the community.

We observed an art therapist working with the patients. The art therapist was offering a structured programme which patients enjoyed participating in.

We also observed joint activities between the patients and staff and patients were observed to have their own music on in their respective bedrooms and lounges. There was a female only lounge as well as enough communal space for patients to relax in.

Patients told us that staff treated them well and they would know how to raise any issues with the staff. We observed that the registered manager was available in the patient areas and patients were able to approach them and the nurse in charge with any issues they had.

Agency staff were well integrated with the permanent members of staff and they were all knowledgeable about the patients and their care.

Involvement in care

Involvement of patients

Staff involved patients and those close to them in decisions about their care, treatment and changes to the service.

Staff involved patients in the development of their care plans and risk assessments. Care plans showed evidence of patients signing their care plans, which were available in easy read formats.

Staff were able to communicate in several ways with patients, this included patients having personalisation flash cards available for their use with preferred calming methods, talking mats and Makaton. There currently wasn't any formalised Makaton training being delivered, and despite the assistant speech and language therapist developing, communication plans with patients who used their own signs of Makaton and did sign of the week to encourage staff to learn on an ongoing basis, this was no substitute for formal Makaton training.

Patients were encouraged to attend their multi-disciplinary meeting, however at the meeting we attended the patients did not want to attend. It was agreed during the meeting that after the meeting staff would go and speak with them and provide an update. Staff spoke about the patient in a respectful, kind and caring way. It was clear they knew the patient well and had knowledge of their behaviours and personality.

The hospital had an advocacy services and patients could access this when required. The advocates would also attend the multi-disciplinary team meetings to support patients.

Inadequate

Wards for people with learning disabilities or autism

Involvement of carers

We received feedback on the service from three carers.

Carers reported that staff were very good. When they visited, they saw good examples of support workers being supportive of their relative even during episodes of aggression. They said that staff managed to talk their relative down calmly. Carers also said that the service contacted them regularly updating them of any recent incidents. The only complaint from carers we received was that their relatives were so far away from home, but they recognised this was not necessarily the hospital's fault.

Carers knew how to make a complaint but had not had cause to do so and said that the hospital encouraged their relative to keep in touch via the telephone. Carers also said that their relatives liked it at the hospital and they had never expressed or given any reason to suggest they were unhappy. They felt that their relatives were safe there.

In the 12 months the services had received 12 compliments. Three of these were from carers of patients.

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

Good

Access and discharge

Bed Management

Chesterholme was a 26 bedded unit, however at the time of the inspection there was only 10 patients living there. All these patients had discharge plans in place. The unit was still accepting referrals.

Not all patients who were resident at Chesterholme were from the local area, and there was one patient there whose family lived six and a half hours away, which the family and the patient were extremely unhappy about.

If a patient required more intensive care than Chesterholme could provide, then the appropriate action was taken, which sometimes included referrals to other providers.

Discharges and transfers of care

In the 12 months leading up to our inspection, there were two delayed discharges due to local authorities being unable to find a suitable placement for the individuals; service specifications had been sent to find an appropriate placement. A further patient has been delayed by three weeks due to a decline in their clinical presentation, however there was now a planned discharge date.

Patients length of stay ranged from 19 years to three months.

Discharge planning started on admission to the service and we observed discussions around discharge taking place within the multi-disciplinary team meeting. Staff planned for these discharges.

All patients had care and treatment reviews in line with NHS England's commitment to transforming services for people with learning disabilities, autism or both.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own areas or rooms where they could keep personal belongings safely. They all had en-suite bedrooms and they could access these at any time of the day. Some patients had an extra room which was used as their own lounge, this allowed them to relax with staff or play music or games, without having to spend time in a main communal area. There were quiet areas for privacy.

Patients were able to personalise their own rooms. Patients told us that they were able to make these rooms their own and we were able to observe this. Rooms were clean and free from odours. Patients had their own locker where they could securely store their possessions.

Some patients were risk assessed to have their own mobile phones, so they could contact their families. If they did not have a mobile phone, staff supported them to contact their families.

There were drink making facilities available all of the time and we observed staff assisting those less able patients to make a drink when they requested. The food was of good quality and was made on site by a catering team. Patients were involved in choices for food and catering staff worked with the assistant speech and language therapist to ensure that meals were suitable for patients who had difficulties with swallowing.

There was a family room to support patients with their visits, they also had a range of rooms for patients to access, including dining rooms, art room, communal lounges, individual lounges, female only lounge, enclosed garden and training kitchens. There was a quiet room which had some equipment for relaxation including bean bags and soft cushions and lights. There were plans to extend this further and make it a relaxation room, including sensory equipment.

Patients' engagement with the wider community

Staff supported patients with their relationships with their families. They were able to visit as they wanted and attend their clinical meetings.

Patients engaged in activities outside the service, and one patient told us that every day she picked up all the post from the unit and delivered it to the post box. Patients could spend some of their time going in to the community with staff to go to the local shops, in to the town centre and attend the local swimming pool, patients told us that they were happy that they could do this.

Meeting the needs of all people who use the service

The service was accessible to all who needed it and took account of patients' individual needs. Staff helped patients with communication, advocacy and cultural support.

The unit was sited on a busy road in an industrial estate and quite a walk from the main town centre, this was not ideal when trying to integrate patients in to local community.

The environment was accessible for patients who had physical needs. It was step free and had a lift to ensure that all patients could also access the bedrooms on the second floor.

While all patients first language was English, staff told us they could access materials from the provider in other languages if needed. Staff could also access interpreters as and when they needed.

Some patients used Makaton, and the assistant speech and language therapist was involved in development of communication plans for them, including ensuring that any modified Makaton signs that the patients used were known by staff. They also did a sign of the week to ensure staff were continually updating their skills. However, staff were not formally trained in the use of Makaton.

There were many examples of easy read and pictorial care plans, including 'my meeting feedback', 'my care plan', 'my day care plan', epilepsy care plans and activity plans.

Noticeboards displayed information for patients in easy read formats around the unit, including how to access advocacy, their rights to complain and how to contact the CQC.

Patients' food was made on site and it could be tailored if necessary to meet the cultural or religious needs of the patients. The hospital also catered for those who had health related dietary needs.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

There had been three complaints in the last 12 months leading up to the inspection. Two of these were upheld and one of these was not upheld, the provider did not provide any further details on these. There were none referred to the parliamentary health service ombudsman. Lessons learned from these complaints was fed back in to the ongoing staff meetings.

Patients knew how to complain or raise concerns. Patients we spoke with told us that they would ask staff. We saw easy read posters available in the unit.

We saw that a patient wanted to make a complaint about another patient. The registered manager took this complaint to deal with and also contacted the advocate to support the patient further to progress this complaint.

The unit also had a 'you said we did' board and topics featured were safeguarding, activities, environment and care and treatment.

In the 12 months leading up to the inspection, the services had received 12 compliments, including some from the police and the clinical commissioning group.

Inadequate

Wards for people with learning disabilities or autism

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

Inadequate

Leadership

The hospital's manager was a registered learning disabilities nurse and had been in post for 18 months. The manager was supported in their role by a deputy manager. This was a new appointment and they had only been in post for two weeks.

The hospital manager and deputy manager were visible in the unit, spending time in patients' areas and joining in the meetings and patient MDTs.

Vision and strategy

Many staff we spoke with could not tell us what were the vision and values for Cygnet Chesterholme.

Chesterholme was previously run by Danshell. In 2018, Cygnet Healthcare purchased the services. This takeover had left the staff unsure as to which policies or governance structures they were following.

We asked for two medicine management policies and a copy of the vision and values; those provided were Danshell's and the two policies for medicine management had not been reviewed since 2017. However, when we asked for the restrictive interventions policy and the seclusion and segregation policy, those provided were titled Cygnet Healthcare.

Culture

Staff felt respected and supported in their role, which was an improvement since the previous inspection in 2018. Staff told us that things had changed, and they felt respected and valued, and a number of staff had been in post for many years and stated that they loved their job and their working environment. Staff said they would able to raise any concerns without the fear of retribution and felt safe to do so including the whistleblowing procedure. Nursing staff, members of the multi-disciplinary team, unit managers and ancillary staff were interviewed, and these were constant themes running through all the interviews.

Managers and the organisation dealt with poor performance and we saw examples of when the manager had to ask people to leave the hospital due to behaviour. This was done quickly and without delay.

Staff received appraisals and in the 12 months leading up to the inspection 91% if staff had received one. Career development and their training needs were discussed at this meeting.

The provider had access to support for staff wellbeing, and staff could access this following incident if needed. The service also had HR clinics for staff to speak with the provider's human resource department following being taken over by Cygnet. Staff sickness was managed well, and the average sickness rate was low at 2%.

Governance

Our findings from the other key questions did not demonstrate that governance processes operated effectively at hospital level and that risks were managed well.

The provider had not ensured that there was sufficient oversight of governance processes.

During our inspection, there were some issues that we identified with governance which were not picked up by the provider.

- Risk assessments and care plans not being updated following incidents, clinical presentation or changes in medication.
- Although Cygnet took over the hospital in 2018, we found that there was a mixture of polices, protocols and paperwork, some which were out of date since 2017 and had not been reviewed.
- Handover documentation was not completed when epilepsy monitors were checked.
- Agency staff personnel files were not up to date and initially had missing DBS, induction and training details missing, although these were subsequently provided to us and added to the folders.

Management of risk, issues and performance

The hospital had a risk register which contained two risks. These related to a whistleblowing around number of staff on duty and the high use of agency staff.

We checked the staff rotas, both at the time of these concerns and for the four weeks leading up to the

inspection. These indicated that staff numbers matched the assessed needs of the patients, but the hospital was using high levels of agency staff. These agency staff were used regularly and had all been trained in conflict management training (MAYBO) and received an induction to the hospital.

Chesterholme had a business continuity management plan which had been updated in April 2019. It covered the immediate responses needed should an emergency occur such as loss of communication, loss of amenities, inclement weather or fire.

Information management

The service collected, analysed, managed and used information well to support all its activities, using a paper system and a secure electronic system to record and report incidents. This information was in an accessible format.

Staff had access to the information technology needed to do their work, ensuring confidentiality of the patient's contemporaneous notes.

Engagement

Some staff stated that they were not quite sure which provider they were working for as Danshell had been taken over by Cygnet, this was evident in paperwork they were using which varied between the previous provider and Cygnet. They did however receive up to date information from the provider such as a bulletin and via the intranet.

Feedback boxes were available in the clinical areas that patients could add feedback in to as well as ongoing regular patient meetings, these meeting minutes were written in symbols and easy read formats.

Learning, continuous improvement and innovation

The unit did not participate in any accreditation schemes

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that recruitment and retention protocols are adequate.
- The provider must ensure that staff are trained in epilepsy and Makaton and learning disabilities.
- The provider must ensure that patients' risk assessments, care plans and positive behaviour support plans are regularly reviewed and updated following incidents and when required.
- The provider must ensure that epilepsy monitors are checked and allocated on each nursing handover.
- The provider must undertake an urgent risk assessment of the need to hold emergency medication, as per the UK standards for cardiopulmonary resuscitation practice.
- The provider must ensure that if staff are undertaking rapid tranquilisation then staff are trained to immediate life support level.
- The provider must undertake an urgent review of both the rapid tranqualisation policy and the medicine management policy to reflect the change in provider.
- The provider must ensure that all agency staff have the correct information in their personal files, including DBS checks, induction paperwork and training certification.

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 18 HSCA (RA) Regulations 2014 Staffing **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 Staffing** Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not available and lacked training in learning disability and autism, Makaton and epilepy. This was a breech of regulation 18 1,2 (a)(b)(c)