Cygnet Yew Trees

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

Overall summary

We completed this focused inspection based on concerning information received about the alleged abuse of patients. We specifically focused on our safe, caring and well led domains.

We did not rate this inspection.

We identified the following areas of concern:

- Some staff did not protect patients from abuse and improper treatment. We reviewed close circuit television (CCTV) footage which showed staff physically and emotionally abusing a patient. Staff who witnessed the incident did not raise or report their concerns to anyone at the hospital. We reviewed 20 further episodes of CCTV footage, saved between May 2020 and July 2020, which we requested from the hospital. Out of these 20 episodes, we identified in 8 (40%) examples of inappropriate staff behaviour, including physical and emotional abuse. No staff reported or raised concerns about this practice. Staff did not recognise when an incident of seclusion occurred and therefore, the patient did not have access to the appropriate reviews and safeguards outlined in the mental health code of practice.
- Staff did not record incidents accurately. We reviewed all incident records relating to the 20 episodes of CCTV we requested. Forty five percent of the reports did not align with the CCTV footage. Staff did not accurately record the descriptions of the incidents and staff did not record the time of incidents accurately. None of the incident forms recorded inappropriate staff behaviour.
- Managers failed to assess, monitor and mitigate risks relating to the health, safety and wellbeing of patients at the hospital and failed to improve the service. We continued to identify breaches of regulations that we raised at previous inspections. The service remained in special measures and had conditions placed on its registration. Managers did not always act on audit outcomes and did not respond to prompts sent about key performance items such as completing supervision.
- Managers had not ensured they took every step to ensure they recruited and continually assessed people with the right skills, experience and values to work with a vulnerable patient group. Managers did not offer regular and robust supervision. They did not review specific agenda areas such as safeguarding and whistleblowing. Staff responsible for recruiting new staff did not always ask all questions at interview, including questions about when to raise concerns. Scores were not always recorded to demonstrate candidates met the recruitment thresholds.

Summary of findings

- Staff contributed to poor culture in the hospital that increased the risk of harm to patients. This included abuse and human rights breaches. Staff did not always report when they witnessed inappropriate behaviour of other staff. When staff did raise concerns, managers did not act on them and take steps to safeguard patients. In one example, where staff raised concerns about practice there was a delay of 509 days before a safeguarding notification was sent to CQC and action was taken to investigate the concerns. Staff described issues with team dynamics, relationships and support from managers. Staff used nicknames for each other that gave weight to a poor culture.

However:

- The hospital acted to suspend staff involved in one incident of abuse and inappropriate behaviour. Managers made appropriate referrals to Police, the Nursing and Midwifery Council and the Disclosure and Barring service. Managers continued to review CCTV footage, after the inspection, to assess additional staff and their treatment of patients. Managers had taken appropriate steps to support patients who were victims, this included offering psychological support. Managers informed families and carers of the incidents.

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		Wards for people with learning disabilities or autism.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Yew Trees

Cygnet Yew Trees is a 10-bed hospital for women aged 18 years and above who have a learning disability. The provider, Cygnet (OE) Limited, took over this hospital in May 2019. This location was registered with the Care Quality Commission on 27 November 2012 for the following regulated activities:

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

The hospital does not have a registered manager. In June 2020 the previous registered manager applied to de-register. The hospital had a manager in place who was processing an application (submitted on 17 June 2020) which was interrupted by human resource processes.

On 30 April 2019 we completed a comprehensive inspection and identified a breach of regulation 12 (safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In October 2019 we issued a section 29 warning notice, following a focused inspection. We completed this inspection after receiving information of concern. We identified continued breaches of regulation 12 (safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also issued a requirement notice for this regulation. We placed the service in special measures in December 2019.

In January 2020, during a comprehensive inspection, we identified breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for regulation 12 (safe care and treatment), 16 (receiving and acting on complaints) and 17 (good governance). We imposed conditions on the provider's registration at this location, under Section 28 of the Health and Social Care Act 2008.

At this focused inspection we identified serious concerns relating to breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for regulation 12 (safe care and treatment), 13 (safeguarding service users from abuse and improper treatment), 17 (good governance) and 18 (staffing).

On 15 September 2020 the provider submitted an application to vary a condition of registration by removing the location Cygnet Yew Trees. The application was invalid because the Care Quality Commission had served a Notice of Proposal on 21 August 2020 to vary conditions by removing this location of Cygnet Yew Trees.

On 8 October 2020 the Care Quality Commission issued a Notice of Decision under section 28(3) of the Health and Social Care Act 2008, to remove the location of Cygnet Yew Trees from the providers registration.

Our inspection team

The team that inspected the service comprised two CQC inspection managers and one CQC inspector.

Why we carried out this inspection

During the COVID-19 pandemic CQC have continued to monitor and assess information from providers and others. Due to receiving concerning information from the provider, relating to alleged abuse of patients, the CQC carried out a focused inspection.

This inspection was unannounced.

Summary of this inspection

How we carried out this inspection

Our focused inspection of this location was very specific to assess if the provider had taken appropriate steps to safeguard patients at the hospital. We also inspected to check if any other patients had been subjected to abuse or inappropriate treatment.

We looked at specific questions under our safe, caring and well led domains.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- Requested and viewed a sample of 20 episodes of the provider's closed-circuit television footage at the hospital;
- Looked at 20 records staff completed for incidents (for the sample of footage seen);
- Looked at 14 records managers completed when recruiting staff to work at the hospital, along with other human resources records;
- Looked at records managers completed when supervising staff;
- Spoke to the hospital manager;
- Spoke to the operations director;
- Spoke with three members of the nursing team;
- Spoke with stakeholders;
- Looked at a range of policies, procedures and other documents relating to the running of the service;
- Requested further information from the service after our visits.

What people who use the service say

We did not speak to patients during this inspection.

We prioritised assessing the safety of the service to understand if staff protected patients from abuse. The nature of our questions for this inspection may have been upsetting and distressing for patients.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not rate this inspection.

We identified the following areas of concern:

- Some staff did not protect patients from abuse and improper treatment.
- Ten staff (8 permanent and 2 agency) were suspended from duty due to allegations of abusing patients, treating patients inappropriately, using excessive force or failing to report poor practice
- We reviewed close circuit television (CCTV) footage which showed staff physically and emotionally abusing a patient. Staff who witnessed the incident did not raise of report their concerns to anyone at the hospital. We reviewed 20 further episodes of CCTV footage, saved between May 2020 and July 2020, which we requested from the hospital. Out of the 20 episodes, we identified that 40% included examples of inappropriate staff behaviour, including physical and emotional abuse.
- Staff did not record incidents accurately. We reviewed all incident records relating to the 20 episodes of CCTV we requested. Forty five percent of the reports did not align with the CCTV footage. Staff did not accurately record the descriptions of the incidents and staff did not record the time of incidents accurately. None of the incident forms recorded inappropriate staff behaviour.
- Staff did not use seclusion appropriately, follow best practice, or recognise when seclusion took place. We witnessed one episode of seclusion on CCTV from 01:17 – 06:01 which staff did not recognise as seclusion. Staff did not record this as seclusion and therefore the patient did not have access to appropriate reviews and safeguards.
- Staff did not use appropriate restraint techniques. CCTV footage showed two examples where staff dragged patients across the floor. This practice is dangerous and puts the patient at risk of harm.

Are services caring?

We did not rate this inspection.

We identified the following areas of concern:

- Some staff did not have the right attitude and values to care for vulnerable patients.

Summary of this inspection

- Through review of CCTV we witnessed abusive, disrespectful, intimidating, aggressive and inappropriate behaviour. We saw examples of staff failing to use communication strategies known to support patients with their emotional needs. We witnessed staff failing to engage and converse with patients whilst undertaking observations, instead standing and watching with arms crossed.
- Staff failed to raise concerns about disrespectful, discriminatory and abusive behaviour and attitudes towards patients as they feared the consequences.

However:

- We reviewed seven episodes of CCTV randomly selected by the inspection team. This included weekends, nights and early mornings. In these examples, staff showed behaviours opposite to the examples above. We saw staff laughing with patients, we saw staff and patients participating in dancing in communal areas. We saw patients relaxing, engaging in activities and being supported by staff.

Are services well-led?

We did not rate this inspection.

We identified the following areas of concern:

- Staff contributed to poor culture in the hospital that increased the risk of harm. This included abuse and human rights breaches.
- Managers failed to assess, monitor and mitigate risks relating to the health, safety and wellbeing of patients at the hospital and failed to improve the service. We continued to identify breaches of regulations that we raised at previous inspections.
- Managers did not have appropriate oversight of governance; they failed to offer regular and robust supervisions to staff, they did not adhere to the provider recruitment policy and did not take appropriate action when staff raised concerns about the service and the people it employed.

However:

- Managers took action to suspend four staff on discovery of one incident of abuse. They made referrals to Police, the Nursing and Midwifery Council, and disclosure and barring services. Managers continued to act to suspend staff as investigations continued after the inspection.

Detailed findings from this inspection

Wards for people with learning disabilities or autism

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are wards for people with learning disabilities or autism safe?

Patient safety

Some staff subjected patients to emotional and physical abuse. We reviewed 21 episodes of closed-circuit television (CCTV) footage and witnessed staff drag, slap and kick a patient. We witnessed staff shove a patient. We witnessed staff using verbal and non verbal communication with patients, the content of which the hospital assessed as a trigger for patients' anxiety. We saw extremely negative interactions where staff visibly became angry with patients, threw items in the vicinity of patients and stood very close to patients with intimidating body language (arms crossed, standing over them).

Managers suspended eight permanent staff from working at the hospital. This followed their identification of abuse on one episode of CCTV footage, and then reviewing the further 20 episodes requested by CQC. Suspension reasons included physical and emotional abuse and for witnessing inappropriate behaviour and not reporting it.

Of the 21 episodes of CCTV reviewed 9 (45%) in total contained examples of staff abusing patients, acting inappropriately or delivering a poor standard of care.

Assessing and managing risk to patients and staff

Some staff did not use restraint as a last resort. They did not attempt de-escalation first. We witnessed this on four episodes of CCTV footage. In two examples, staff dragged patients across the floor and did not use the correct restraint techniques. In one example staff used elbows in a patients abdomen to alter their position, whilst the patient was restrained on the floor. In four examples of CCTV footage, staff did not support the head of a patient who required this during restraint. Care plans required this to reduce the likelihood of the patient causing themselves harm by banging their head. In six examples of CCTV where restraint took place it showed all male staff teams restraining female patients. There were no examples where female staff were swapped into the restraint team, despite being available on shift and, in some cases, being in the room during the restraint. We witnessed one staff member responding quickly to cover a patients abdomen during a restraint to protect their dignity. In two other examples staff responded to dignity issues but it was not immediate. Staff did not always attempt to distract other patients present in rooms when restraints took place. In two examples of CCTV footage we witnessed other patients trying to involve themselves in the restraint of another patient.

Staff did not use seclusion appropriately, follow best practice, or recognise when seclusion took place. We witnessed an episode of seclusion on CCTV from 01:17 – 06:01. Seclusion is defined as 'the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.' (Mental Health Act Code of Practice 1983, revised 2015 chapter 26. 103). Staff prevented a patient leaving their bedroom area between these times. Staff did not recognise this as seclusion and did not record the event as seclusion. This meant the patient did not have access to appropriate reviews and safeguards outlined in the Mental Health Act Code of Practice.

Safeguarding

Staff did not recognise and report abuse. In 45% of the episodes of CCTV multiple staff witnessed abusive and inappropriate behaviour and did not report a safeguarding concern. This was despite records showing 96% of staff received safeguarding training.

Wards for people with learning disabilities or autism

Following the inspection and review of 20 requested episodes of CCTV, CQC received 11 safeguarding notifications relating to the recorded episodes.

Managers did not ensure safeguarding was discussed consistently and regularly during supervision. In fourteen human resource records, there were three examples of safeguarding not being discussed in records. Quality assurance managers highlighted this to hospital managers during audits of records, however the issue continued in later records.

Reporting incidents and learning from when things go wrong

We looked at all incident forms relating to the 20 episodes of CCTV reviewed. We also reviewed the incident form relating to the episode of abuse found during a CCTV audit which took place on 18 July 2020.

Staff did not record incidents accurately. Of the incident forms reviewed, staff did not record information correctly in forty five percent of examples. Staff did not record the events leading up to incidents accurately; in two examples staff described patients behaviour as agitated, but this did not match the images on CCTV. Staff did not record times accurately, the examples we included in this judgement did not include incidents where the time was inaccurate by under 30 minutes. We recognise when incidents occur, due to their nature, the time they are recorded may not be accurate to the minute. The examples we have included in the judgement were inaccurate by between 30 minutes and two hours.

We specifically requested episodes of CCTV that linked to recorded incidents. In three examples of CCTV footage it did not show an incident taking place. The information staff recorded on the incident form was inaccurate in either content, date or time. We were unable to establish when the recorded incidents took place.

Are wards for people with learning disabilities or autism effective?
(for example, treatment is effective)

We did not inspect this key question.

Are wards for people with learning disabilities or autism caring?

Kindness, privacy, dignity, respect, compassion and support

Some staff did not have the right attitude and values to care for vulnerable patients. Through review of CCTV we witnessed abusive, disrespectful, intimidating, aggressive and inappropriate behaviour. We saw examples of staff failing to use strategies known to support patients with their emotional needs. We witnessed staff failing to engage and converse with patients whilst undertaking observations, instead standing and watching with arms crossed.

We reviewed seven episodes of CCTV randomly selected by the inspection team between 26 June 2020 and 30 July 2020. This included weekends, nights and early mornings. In these examples, staff showed positive, caring and fun behaviours towards patients. We saw staff laughing with patients, we saw staff and patients participating in dancing in communal areas. We saw patients relaxing, engaging in activities and being supported by staff.

Staff did not raise concerns about practice when they should have done. Reasons for these included issues with staff team dynamics, issues with personalities, a belief that managers did not take concerns seriously and did not act due to favouritism. Some staff feared repercussion.

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

We did not inspect this key question.

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

Culture

Staff contributed to poor culture in the hospital that increased the risk of harm. This included abuse and human rights breaches. Staff lacked the confidence and integrity to raise concerns about poor patient care. No staff raised

concerns about the examples of abuse and inappropriate staff behaviour that took place in the CCTV footage. Staff used nicknames for each other that gave weight to a poor culture.

Staff reported a variety of concerns relating to team dynamics and alleged favouritism and intimidation which they said made them fearful of reporting. In three (from 14 human resource files) supervision records staff reported concerns relating to members of staff and managers did not record how they intended to address concerns, Managers did not follow up concerns in later supervision sessions.

Staff we spoke with knew the contents of the whistleblowing policy and knew they could have used this method to report their concerns.

Managers took action to suspend staff on discovery of CCTV footage which showed abuse. Managers spoke with a nursing staffing agency to inform them of concerns relating to two registered staff. The provider sent an alert to all services to ensure they did not use the agency staff implicated. Managers reported the abuse to Police and made referrals to the disclosure and barring service.

After inspection visits, managers continued to review the footage requested by CCTV and suspended a further 6 staff from the hospital due to issues of abuse, excessive force and inappropriate patient care. Investigations remained ongoing.

Governance

Managers did not ensure they offered staff regular and robust supervision to reflect on their performance and to ensure their understanding of key items such as safeguarding. We looked at fourteen staff files. Seventy one percent of staff did not receive supervision in line with the provider's policy.

Managers did not implement recommendations from supervision audits. Of particular concern was that managers did not follow up issues raised by staff including; staff practice and issues within the team.

Managers did not discover further incidents of abuse and poor staff practice through audits of CCTV. This was despite a member of the leadership team explaining the provider expected all incidents involving restraint to be reviewed at a hospital of this size.

Managers had not ensured they took every step to ensure they recruited and continually assessed people with the right skills, experience and values to work with a vulnerable patient group. Staff responsible for recruiting new staff did not always ask all questions at interview, including questions about when to raise concerns. Scores were not always recorded to demonstrate candidates met the recruitment thresholds. In four examples, on average managers recorded answers for 56% of questions. Managers failed to assess risk in two examples of recruitment where staff disclosed information on applications.

Managers failed to assess, monitor and mitigate risks relating to the health, safety and wellbeing of patients at the hospital and failed to improve the service. We continued to identify breaches of regulations that we raised at previous inspections.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that patients are protected from abuse and improper treatment.
- The provider must ensure that patients are treated with kindness, dignity and respect.
- The provider must ensure that staff recognise and report abusive and improper practice.
- The provider must ensure that it responds, in a timely way, to any concerns raised by staff relating to practice and issues relating to the service.
- The provider must ensure that appropriate safeguarding referrals are made when abuse is identified.
- The provider must ensure that they operate effective systems to investigate and allegation or evidence of abuse.
- The provider must ensure that service reviews closed circuit television in line with the required organisational procedure.
- The provider must ensure staff record accurate descriptions of incidents in a timely way.
- The provider must ensure that staff recognise and record the use of seclusion and adhere to seclusion guidelines reflected in the mental health act code of practice.
- The provider must ensure that staff use appropriate restraint techniques to reduce the risk of patients experiencing harm.
- The provider must ensure that staff use the appropriate communication techniques and strategies known to be effective in supporting patients.
- The provider must ensure the culture at the hospital protects patients from harm and upholds their human rights.
- The provider must ensure they assess, monitor and mitigate risks relating to the health, safety and wellbeing of patients at the hospital and act to improve the service.
- The provider must ensure that staff have access to regular and robust supervision.
- The provider must ensure that they recruit staff with the right attitudes, behaviours and values to work with a vulnerable patient group.
- The provider must ensure that the service adheres to the policies and procedures of the organisations including: safeguarding, recruitment and incident reporting.
- The provider must ensure they act on findings of quality audits.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment On 15 September 2020 the provider submitted an application to vary a condition of registration by removing the location Cygnet Yew Trees. The application was invalid because the Care Quality Commission had served a Notice of Proposal on 21 August 2020 to vary conditions by removing this location of Cygnet Yew Trees. On 8 October 2020 the Care Quality Commission issued a Notice of Decision under section 28(3) of the Health and Social Care Act 2008, to remove the location of Cygnet Yew Trees from the providers registration.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment On 15 September 2020 the provider submitted an application to vary a condition of registration by removing the location Cygnet Yew Trees. The application was invalid because the Care Quality Commission had served a Notice of Proposal on 21 August 2020 to vary conditions by removing this location of Cygnet Yew Trees. On 8 October 2020 the Care Quality Commission issued a Notice of Decision under section 28(3) of the Health and Social Care Act 2008, to remove the location of Cygnet Yew Trees from the providers registration.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance On 15 September 2020 the provider submitted an application to vary a condition of registration by removing the location Cygnet Yew Trees. The application was invalid because the Care Quality Commission had served a Notice of Proposal on 21 August 2020 to vary conditions by removing this location of Cygnet Yew Trees. On 8 October 2020 the Care Quality Commission issued a Notice of Decision under section 28(3) of the Health and Social Care Act 2008, to remove the location of Cygnet Yew Trees from the providers registration.
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 On 15 September 2020 the provider submitted an application to vary a condition of registration by removing the location Cygnet Yew Trees. The application was invalid because the Care Quality Commission had served a Notice of Proposal on 21 August 2020 to vary conditions by removing this location of Cygnet Yew Trees. On 8 October 2020 the Care Quality Commission issued a Notice of Decision under section 28(3) of the Health and Social Care Act 2008, to remove the location of Cygnet Yew Trees from the providers registration.