Cygnet Newbus Grange

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?	**Requires improvement**
Are services responsive?	**Inadequate**
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

Overall summary

We carried this unannounced inspection in response to concerns that had been shared with us about the leadership and culture at Newbus Grange. We looked at the specific concerns which had been reported to us and have reported on these in the safe and well led domains. The ratings for these domains remains the same, which means the rating for the service is unchanged since the May 2019 inspection.

The rating of Newbus Grange remained the same. We rated Newbus Grange as inadequate because:

- Not all areas of the hospital were clean. We found sticky floors and door handles; dead flies, cobwebs, thick dust and plaster debris on some windowsills; and there was an unpleasant odour of urine in some patient bedroom areas. A door to a food storage area marked "keep closed" was left open and unattended. Some patient bedrooms had no window covering and one bedroom window blind cord posed a risk of accidental or intentional hanging. The provider removed this risk after we pointed it out to them.
- Staff did not effectively identify and respond to poor care practice. Staff had training on how to recognise and report abuse and they knew how to apply it but were less able to identify and report poor care practice. The body language and posture of some staff who were present during restraint was not always inclusive or calming. It was remote and authoritarian at times, showing staff with their hands on their hips or pointing their fingers. Such body language can have a negative impact on the person being restrained and could in fact prolong the incident.
- The delivery of high quality care was not assured by the leadership, governance or culture of the hospital. There was no understanding of the importance of culture. Leaders failed to identify and challenge all elements of poor staff practice. This had led to the development of an unrecognised, unhealthy culture. We heard allegations suggesting that some permanent staff showed intolerances of a racial, gender or cultural nature. Staff were frequently observed talking with each other and not engaging with the patient they were working with. This poor practice went unreported and unchallenged.
- Staff failed to implement de-escalation techniques before moving to apply supine restraint in each of the seven incidents we reviewed.
- Nurses were not able to spend as much time on the ward as they would prefer or as much time as would be beneficial to running of the ward because they had to spend a lot of time in the office.
- Recruitment procedures were not robust. There was no evidence the provider had considered the suitability, or made adjustments, for staff with criminal convictions or cautions to work with vulnerable adults.
- Supervision processes were not robust and the staff supervision matrix was not up to date. Between January and June 2019, 10 staff had no supervision. Nursing staff did not engage in clinical supervision and there was no reflective work done with support workers. Managers did not effectively analyse why staff left the service. Staff turnover was high, 39% at the last inspection in May 2019.
- There were high levels of violence in the hospital and allegations of discrimination. Leaders were not taking adequate action to address this. Support workers and nurses were regularly assaulted by patients. Injuries included being bitten, scratched, kicked and fingers bent backwards. These were often not reported. One member of staff who had left the organisation, told us they were seen as weak because they were frightened by patients who assaulted and hurt them. Several staff told us they were not given enough information or support when they started working at Newbus Grange. They had not been prepared for the level of violence and aggression they would encounter from patients.
- Incident reports did not always accurately reflect the incident. We found discrepancies in the description of some incidents and the number of times physical intervention had been used. Staff did not always follow a patient's positive behaviour support plan or care plan during incidents.
- A room used for family visits contained files with patient activity information inside them.

However:

- Staff observed good hand hygiene principles. The ward was mostly safe, well equipped, well furnished, and fit for purpose.

Summary of findings

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff were confident there was no abuse taking place the hospital. They told us they would know if other staff were delivering care in a way which was unacceptable and if they discovered issues of concern they would report it straight away.

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**		Please see detailed findings section

Summary of findings

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Inadequate

Newbus Grange

Services we looked at

Wards for people with learning disabilities or autism;

Summary of this inspection

Background to Cygnet Newbus Grange

Newbus Grange is an independent, specialist hospital that provides assessment, treatment, care and support for men with a primary diagnosis of autism, learning disability and complex needs. The service is registered and accredited with the National Autistic Society and the Royal College of Psychiatrists' Quality Network for Inpatient Learning Disability Services (QNLD).

The service is provided for men who, because of their complex needs, cannot yet be cared for in a community setting. They may be stepping down from secure services or may present significant risks to themselves or to other people. The service aims to support patients to work toward discharge into a community placement, one patient was about to be discharged to his new community placement when we carried out this focussed inspection.

Newbus Grange is registered with CQC to provide:

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

The service had a registered manager but had recruited a replacement, who was due to take up post in June 2019.

The service had been inspected on five previous occasions:

- January 2016, routine comprehensive inspection. The service was rated as good overall with requires improvement in the effective domain.
- October 2016, focussed inspection. The effective domain was upgraded to good.
- May 2017, responsive focussed inspection, as a result of information of concern that was received. The service was rated as good in the caring domain.
- Comprehensive routine inspection in December 2018. The service was rated as outstanding overall with good in the safe, effective and responsive domains and outstanding in the caring and well led domains.
- Comprehensive inspection in May 2019, as a result of concerns received. The service was rated inadequate overall with requires improvement in caring and effective and inadequate in safe, responsive and well led. We issued the service with a Notice of Proposal following this inspection, which meant the provider had to comply with a clear action plan to evidence how they would improve the service.

At the time of our inspection in June 2019 there were 10 patients receiving care and support at Newbus Grange.

We have submitted closed circuit television evidence of incidents involving patient restraint for independent analysis and may take further action against the provider once the findings are available.

Our inspection team

The team that inspected Newbus Grange comprised three CQC inspectors, an inspection manager, a head of hospitals inspection and a deputy chief inspector. This was a responsive, focussed inspection, carried out with very short notice, so we were unable to involve an expert by experience. An expert by experience is a person who has lived experience of using health and care services or is the carer of a person using services.

Why we carried out this inspection

We inspected this service because we had received concerns about the management and culture at Newbus Grange. We needed to investigate these concerns as a priority. We carried out this focussed inspection in response to the concerns. We inspected the safe and well led domains.

This was a focussed inspection, following information of concern we had received. A focused inspection is more targeted and looks at specific concerns rather than gathering a holistic view across a service. The concerns we were told about related to the way key safety and management issues were dealt with.

Summary of this inspection

However, we had carried out a comprehensive inspection three weeks previously, when we looked at the whole service. Please see our website to read a copy of the report which details the May 2019 inspection in full.

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?

Before the inspection visit, we reviewed information that we held about Newbus Grange. We asked a range of other organisations for information including the clinical commissioning groups who commission the service.

During the inspection visit, the inspection team:

- visited Newbus Grange, looked at the quality of the environment and observed how staff were caring for patients
- spoke with the deputy manager, regional operations director, national learning disability practice lead and regional medical director for the service
- spoke with 13 other staff members; including support workers, nurses and auxiliary staff
- received feedback from four members of permanent and agency staff who had left Newbus Grange within the previous six months
- received feedback about the service from commissioners
- spoke with two external professionals who were visiting to assure themselves of the quality of care for their patients
- spoke with a visiting professional who was working in a transitional capacity to support a patient's discharge
- looked at a range of policies, procedures and other documents relating to the running of the service
- wrote to 15 staff who had left Newbus Grange within the preceding six months
- wrote to agency staff who had worked shifts at Newbus Grange within the previous six months
- wrote to 85 staff who were currently working at Newbus Grange
- analysed the closed circuit television footage relating to a number of specific patient incidents where staff had used restraint.

What people who use the service say

This was a targeted, focussed inspection, following information of concern we had received. The concerns related to the way key management issues were dealt with. Consequently, we did not speak with patients or carers during this inspection. However, we had carried out a comprehensive inspection three weeks previously, when we had spoken with patients and carers. Please visit our website to read a copy of the report which details the May 2019 inspection in full.

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:

- Not all areas of the hospital were clean. We found sticky floors and door handles, cobwebs in food preparation areas, thick dust and plaster debris on some windowsills. There was a strong unpleasant odour of urine in some patient bedrooms.
- Staff did not effectively identify and respond to poor practice.
- Staff failed to implement de-escalation techniques before moving to apply supine restraint in each of the seven incidents we reviewed. Use of restraint continued to rise at the hospital, even though there was a reduction plan in place.
- One patient bedroom had an exposed window blind cord, posing a risk of accidental or intentional hanging. Managers removed this soon after we pointed it out to them.
- A door to a food storage area marked “keep closed” was left open and unattended several times during the inspection.
- Incident reports we reviewed did not all correspond with CCTV footage.
- There was limited evidence that managers implemented learning and changes to improve safety for patients following incidents and routine analysis of CCTV footage audits.
- The provider did not have robust recruitment or staff supervision processes.

However:

- Before working unsupervised in the service, all staff had received training in a learning disability specific conflict resolution programme (de-escalation and restraint techniques). Agency and bank staff were required to have undertaken the same conflict resolution training as permanent staff.
- All staff had undergone a period of induction before working in the service.
- All current staff told us they could request and receive adhoc supervision when they needed it, even at short notice.
- Managers had carried out routine audits and analysis of the CCTV footage, which in one instance had led to the discovery of abusive staff practice, resulting in a police investigation and employment dismissal.

Are services effective?

Requires improvement

We did not inspect this domain during this inspection.

Summary of this inspection

We carried out a comprehensive inspection three weeks previously, when we rated this domain as requires improvement. Please see our website to read a copy of the report which details the May 2019 inspection in full.

Are services caring?

Requires improvement

We did not inspect this domain during this inspection.

We carried out a comprehensive inspection three weeks previously, when we rated this domain as requires improvement. Please see our website to read a copy of the report which details the May 2019 inspection in full.

Are services responsive?

Inadequate

We did not inspect this domain during this inspection.

We carried out a comprehensive inspection three weeks previously, when we rated this domain as inadequate. Please see our website to read a copy of the report which details the May 2019 inspection in full.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- The delivery of high quality care was not assured by the leadership, governance or culture of the hospital. Processes did not identify areas for improvement.
- Leaders failed to identify and deal with all elements of poor staff practice. This had led to the development of an unhealthy workforce culture. One ex-member of staff told us that a small number of staff taunted patients as a form of entertainment.
- There were high levels of violence in the hospital and allegations of discrimination. Leaders were not taking adequate action to address this. Support workers and nurses were regularly assaulted by patients. There were allegations that permanent staff showed racial intolerances and gender specific intimidation to colleagues, including to agency workers.
- Managers failed to identify that staff were not trying to de-escalate patient incidents before moving into full supine restraint.
- Managers did not have good oversight of recruitment processes and procedures.
- Managerial oversight of staff supervision and support was not effective.
- There was no effective analysis of why staff left the service. Staff turnover rates were high (39% at the last inspection).
- Staff who no longer worked for the service told us they were given very little support to prepare them and enable them to safely carry out their roles.

Summary of this inspection

However:

- All the staff we spoke with told us they received adhoc supervision when they needed it, even if they requested it at short notice or needed it when working a night shift.
- Staff told us they had confidence in the management of Newbus Grange and trusted that when they reported issues of concern, the matter was dealt with quickly and dealt with well.
- All the staff we asked told us they were confident that issues they raised with managers were treated and remained in confidence.
- Every member of staff we spoke with told us they firmly believed they would know if someone at Newbus Grange was providing unacceptable care, they would report it and were confident managers would deal with it immediately.

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.

We did not inspect the provider's practice and compliance with the Mental Health Act 1983 during this inspection.

We carried out a comprehensive inspection three weeks previously, when we rated this domain as requires improvement. Please see our website to read a copy of the report which details the May 2019 inspection in full.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not inspect the provider's practice and compliance with the Mental Capacity Act 2005 during this inspection.

We carried out a comprehensive inspection three weeks previously, when we rated this domain as requires improvement. Please see our website to read a copy of the report which details the May 2019 inspection in full.

Overview of ratings

Our ratings for this location are:

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

Inadequate

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

Safety of the ward layout

Maintenance, cleanliness and infection control

- We had inspected Newbus Grange three weeks before we carried out this inspection. At that inspection we informed managers about a risk posed by the unguarded cord of a window blind in a patient's room. We told the provider that there was a potential risk of accidental or intentional hanging from this window blind cord. When we returned to carry out this inspection, nothing had been done to remove or reduce the potential risk arising from the unguarded window blind cord. Following this inspection, the provider confirmed to us they had removed the blind cord.
- The environment was generally dark, worn and tired in places with some areas which were better maintained than others. We saw evidence of ongoing maintenance and replacement of furniture. Patients who destroyed their furniture were provided with replacements. Dining room furniture had also recently been replaced.
- The windows to the art and crafts room had pieces of wood falling from them. These appeared to have been stuck to the windows in a decorative manner but some had become loose and detached. Several of these were on the ground and could be used as weapons or tools of self-harm. There was a broken oil filled radiator in the art and crafts room. One wheel was missing, which could have rendered the appliance unsafe were it used. One lounge had a damaged door and wall where it appeared that something had struck it.
- Following the previous inspection three weeks earlier, the provider had undertaken a "deep clean" of some patient areas. However, there was still an unpleasant odour of urine in some patient bedroom areas. Staff told us it would take more than one deep cleaning to remove the odours and they would undertake this on a regular basis.
- Whilst the hospital environment was visibly clean in most areas, we found dead flies and cobwebs on windowsills, including the in the main kitchen where patient food was prepared. There was thick dust on windowsills in the art and crafts room. A pile of plaster debris, which appeared to have been picked out of the wall, lay on one windowsill. This could pose a risk if ingested so we informed staff during the inspection. Some door handles were sticky as were some floors we walked on. One lounge floor was damaged, with uneven patches. This was a particular risk for patients with an unsteady gait, of which there was at least one at the hospital.
- A door to a food storage area marked "keep closed" was left open and unattended several times during the inspection. We informed staff who closed the door but we found it had been left open again later in the day.

Safe staffing

Nursing staff

- We carried out this inspection over two days and one night during a weekend then we returned for a further day midweek. The provider did not know we were planning this inspection, so staffing levels were as they

would have been had we not been there. We found that there were enough qualified nurses and support workers to provide the level of care required. On the first day of the inspection, there were two registered learning disability nurses, a senior support worker and 20 support workers to provide care and treatment for the 10 patients at Newbus Grange. Of the 20 support workers, two were allocated to "float" and provide support wherever it was needed. The deputy manager and regional practice development nurse were also available to support the staff team, both of whom were registered nurses. Managers had identified the number and grade of staff needed to fulfil the requirements of the shift. The number of staff needed and scheduled to work, were working. Visiting NHS staff, who were there for part of our inspection, confirmed they had no concerns about staffing numbers during the inspection.

- There were enough staff to enable patients to participate in scheduled and unscheduled activities, including those taking place in the community.
- There were enough staff to carry out physical interventions, such as observations and restraint when required.
- There was not a qualified nurse in communal areas at all times. We observed, and staff confirmed, that the qualified nurses in charge of each shift spent most of their time in the staff office completing tasks which were important, but which took them away from the patient areas. Support workers were able to approach nurses to ask for support and nurses attended each episode of patient restraint. One nurse told us they wished they could spend more time with patients and said patients associated nurses with administering medicines. Because nurses were not able to spend much time in the patient areas, a senior support worker appeared to be managing the environment. We would expect nurses to have sufficient time in their working shift to be able to spend time in patient areas, interacting with patients and staff whilst also observing the environment and care being provided. Qualified nurses are key to the monitoring of care quality during a shift and ensuring that patient engagement and observations are carried out to an appropriate standard. Qualified nurses are trained to interpret and plan for patient behaviours, to identify antecedents which could lead to incidents. Qualified nurses manage and support unqualified staff to learn and develop their practice. The qualified nurses at Newbus Grange did not have sufficient time to routinely undertake these key aspects of their role.
- All staff had received an appropriate induction before working unsupervised at Newbus Grange. Agency and bank staff were also required to complete an induction before working at the service. Staff rotas allowed a maximum of two members of staff to work a day shift in a supervised, supernumerary capacity, as part of their induction. Bank and agency staff were given time to familiarise themselves with the ward and with patient care plans.
- All staff completed a programme of conflict resolution training. This included de-escalation and restraint. The programme was accredited by the British Institute of Learning Disabilities. Agency and bank staff attended the same level of conflict resolution training as permanent staff. If agency staff had not completed the relevant conflict resolution training they were not permitted to work at the hospital. Staff explained they could have two support workers on shift who had not fully completed their induction but these staff would be supernumerary and were not able to carry out patient engagement and observations without supervision from an experienced member of staff. They were also not allowed to participate in any episodes of patient de-escalation or restraint.
- We looked at seven staff files. We found that the provider did not have sufficiently robust recruitment procedures to ensure they only recruited fit and proper staff. The processes did not provide assurance that, existing staff remained fit and proper to carry out the role for which they had been employed. There was no evidence that the provider had considered the suitability of staff with criminal convictions or cautions to work with vulnerable adults. Only one out of seven staff files, contained evidence that the provider had consulted the Disclosure and Barring Service barred list (these lists contain the names of people barred from working with either children or adults). Whilst the provider's head office retained copies of relevant employment checks, we would expect managers to be able to assure themselves of the suitability of their staff. For staff with declared criminal convictions this would include acknowledgement of the offence or caution accompanied by a risk assessment to show that risks had been considered and mitigated. There were no such

risk assessments and when we asked a manager, we were told there were no staff to whom this would apply. This was incorrect because there were such staff employed to work at the hospital. Staff files contained incomplete interview records and no explanations to cover gaps in employment history for two staff. One file did not contain evidence of a Disclosure and Barring Service check, it merely contained an email from 2016 relating to the check.

- Whilst most staff received adhoc supervision, this was not planned and staff could be called upon without notice to have their supervision. We found that 10 staff had not received any recorded supervision between January and June 2019, all but one of whom had worked shifts during the period. For May 2019, 37 staff were due for supervision but only 16 had received it. Supervision is a key element to support staff, monitor their development and ensure their values remain in line with the provider's vision and values.
- Only one member of nursing staff was seen to have received recent a clinical supervision. Clinical supervision is important for nursing staff to reflect and improve their practice. Whilst unqualified staff could attend patient formulation meetings, there was no formal reflective practice for them to engage with as a means of improving their practice. Routine supervision was of a management style, considering conduct rather than practice and reflection.

Assessing and managing risk to patients and staff

Use of restrictive interventions

- All staff were found to have received training in learning disability specific conflict resolution programme (de-escalation and restraint techniques) before working unsupervised in the service. Agency and bank staff were required to have undertaken the same conflict resolution training as permanent staff before being allowed to work unsupervised in the service.
- Levels of restraint in the service were high and had increased significantly over time. There were 16 recorded incidents of restraint in 2016 for 12 patients in the six months leading up to our inspection that year. This had risen to 1069 incidents for 17 different patients between 1 April 2018 and 14 May 2019. There was no clear analysis available to consider and address this rise. The provider had a plan in place to reduce restrictive interventions but nonetheless they had risen significantly.The provider later told us their analysis of this data showed there had been a decrease in the use of high level interventions, including floor restraints.
- Staff told us they only used restraint when de-escalation techniques had failed. However, our analysis of incident reporting and closed circuit television footage did not corroborate this. We reviewed six incidents against corresponding CCTV footage during our inspection on 1 June 2019 and a further nine when we returned on 12 June 2019. We saw evidence that appeared to show staff using restraint before trying de-escalation. Our analysis showed that staff routinely applied holding techniques in the first instance. In some cases these moved immediately to taking the patient into the supine position. We saw limited low level holding, distraction or diversion techniques being applied by staff beforehand in some of the footage we reviewed.
- One incident we reviewed showed a patient being taken into a supine restraint 29 times during a 30 minute period, from both a standing and sitting position. The care plan for this patient stated that this should happen for a maximum of five times during an incident. It was unclear why this restrictive intervention had been care planned as the most effective for the patient. It was also evident that the patient banged their head twice during the incident. During this incident there were numerous times when staff appeared to be talking amongst themselves and not communicating with the patient. Prior to another incident we reviewed, there was little interaction between staff and patient. The patient's care plan noted that boredom was one of their triggers for incidents. Staff were seen talking to each other, one was arranging their hair immediately prior to the incident. A known incident trigger appeared to have gone unnoticed by staff, which could be the reason for the incident having taken place.
- Analysis of the incident reports and CCTV footage identified a number of staff practices we would assess as poor. These included staff playing with their hair and chatting to each other when they were carrying out patient engagement and observations. We observed a member of staff standing with their hands on their hips during a patient incident and one member of staff with her hair having fallen over the patient's face during an episode of restraint. One member of staff is seen to kick a patient's shoe across the room to the patient following an incident. Another is seen laughing. We determine

that body language of this nature is not acceptable. Body language is a key element of supportive and caring interaction with patients. Body language is a tool of nonverbal communication. Poor body language could contribute to patient incidents, particularly if patients feel unsupported during a period of unsettled behaviour. We have submitted our evidence for independent analysis and may take further action against the provider once the findings are available.

- Managers carried out regular audits of the CCTV footage. The provider had a standard template and policy to support this process. We looked at a number of the audits. There was no evidence that managers implemented changes following the routine audits they carried out of the CCTV footage. We would expect to see discussion with staff to improve practice and to learn from analysis of the observation and engagement with patients, particularly where these have led to incidents involving the use of restraint.
- A member of staff who no longer worked at Newbus Grange told us that they had almost never used restraint whilst working there but that some staff used it on a more or less on a daily basis. They told us they believed that some staff purposely antagonised patients so they could use restraint.
- During our inspection in May 2019, we identified that some patients' bedrooms were bare of personal possessions. We looked at care plans to understand the clinical need and justification for these restrictions. We found that the documentation did not sufficiently support the restrictions and did not evidence that the restrictions were in the patients' best interests. Following the inspection, we asked the registered manager to provide us with additional relevant documentation so we could review it. However, they did not supply the information. When we carried out this inspection in June 2019, we looked at these care plans and found that staff had not used the intervening period to make the necessary updates to assess and document why the restrictions were deemed necessary. Without sufficient documentation to explain why a patient had limited furnishing and fittings to their room, we concluded that these practices were overly restrictive. Following the inspection, the provider did carry out patient specific assessments to address this.
- The provider used the term "sterile room" to describe the requirements for some patient bedrooms. However, there was no clear explanation and no policy to inform staff what a "sterile room" was or what one might look like. A lack of clear explanation could lead to various interpretations of the requirements, which could lead to an environment that did not fully meet with the requirements of the risk assessment. Alternatively, it could lead to an overly restrictive environment, where patient rooms lack personalisation, for which there is no clear justification.

Safeguarding

- Staff told us they were certain there was no abuse of patients taking place at Newbus Grange. They were confident they would be able to identify abuse and would report it straight away. Records showed that staff routinely reported safeguarding concerns to the local authority and commissioners.
- However, whilst we saw examples of staff having reported poor practice, such as a member of agency staff being asleep on duty and a member of staff using a mobile phone on duty, we observed other poor practice which had not been challenged or reported.
- Staff reported obvious incidents of abuse, but less subtle, acts of neglect and omission such as ignoring patients, not following care plans or engagement plans, not interacting with individual patients during observations and prolonging incidents of restraint were not recognised as meeting criteria for a concern (as detailed in Section 42 of the Care Act 2014).
- Our analysis of CCTV footage showed there were a number of behaviours and practices, which showed staff lacked a full understanding of safeguarding. This lack of understanding extended to managers who reviewed the CCTV footage as part of routine audits. Our analysis covered just two inspection days and we saw evidence of poor safeguarding practice. It is unlikely that our observations were unique in content, so managers who reviewed the CCTV footage over time could not have failed to observe similar practices.
- We found one instance where the manager and regional manager had been made aware of a member of staff swearing when slapped by a patient, but this had not been reported as safeguarding until several months later.
- One member of staff who no longer worked at Newbus Grange told us that some staff intentionally antagonised

patients so they could use restraint. They told us they left the hospital after a colleague asked them "how they were with their fists" when they were deployed to work with a particularly volatile patient.

Track record on safety

Reporting incidents and learning from when things go wrong

- All the staff we asked said they knew what incidents to report and how to report them. Support staff told us they wrote the incident details in the patient daily records and nursing staff copied the information into an incident report. Nursing staff completed and submitted the incident report using the company reporting system. All current staff told us they wrote up the incident information as they recalled it and had never been asked to change what they had written. One member of staff told us that managers might ask for additional information, for example if there had been differing reports of an incident. In these circumstances each worker had been asked for a written summary of the incident so the manager could review each one. However, our analysis of CCTV footage showed there were incidents which staff should have reported but did not, including a patient banging their head during a prolonged period of restraint and a member of staff kicking the patient's shoe across the room rather than handing it back to them.
- We looked at a number of incident reports alongside closed circuit television (CCTV) footage for the reported time and location of the incident. We did this to see if the incident reports matched with what was recorded on the CCTV footage. The incident reports we reviewed did not correspond with the CCTV footage in four out of the six incidents we reviewed on 1 June and in five out of seven we reviewed on 12 June. In two of these cases, the incident described in the report was not evident on the CCTV footage at the time stated, nor was it evident within a 15 minute range either side of the reported time. In two other cases, the incident report did not accurately reflect the incident as it appeared on the CCTV footage. Examples included a disparity between the number of times staff used restraint and the number of times it had been recorded as used. One incident showed staff administering PRN (as required) medication but there was no mention of this in the incident report. We would expect the medicines administered during an incident to be recorded in the incident report.
- Some staff told us they were not aware of any information sharing which would lead them to learn from incidents and improve the way they did things.
- Staff were not always given feedback from investigation of incidents. One member of staff told us they had not been updated with an outcome after they had provided evidence relating to an incident of poor staff practice, which they had reported. However, we saw managers had held staff meetings to discuss serious incidents, including one relating to a nearby service which had been featured in the media, where the quality of care had been seriously compromised.
- Staff told us they were offered support following incidents. However, one ex-member of staff told us that if they were upset after having been attacked by a patient, they were seen as weak by some staff. They said that some patients routinely targeted female staff and they had not been made aware of this when applying for the job. Staff routinely experienced injuries after having been assaulted by patients. Some staff had evidence of deep scratches and damage to their skin where patients had assaulted them. They did not routinely report these injuries.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

We did not inspect this domain during this inspection.

We carried out a comprehensive inspection three weeks previously, when we rated this domain as requires improvement. Please follow this link to read that inspection report:

Inadequate

Wards for people with learning disabilities or autism

Are wards for people with learning disabilities or autism caring?

Requires improvement

We did not inspect this domain during this inspection.

We carried out a comprehensive inspection three weeks previously, when we rated this domain as requires improvement. Please see our website to read a copy of the report which details the May 2019 inspection in full.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Inadequate

We did not inspect this domain during this inspection.

We carried out a comprehensive inspection three weeks previously, when we rated this domain as inadequate. Please see our website to read a copy of the report which details the May 2019 inspection in full.

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

Inadequate

Leadership

- We carried this unannounced inspection in response to concerns that had been shared with us about the leadership at Newbus Grange.
- We found that leadership was lacking in key fundamental areas to monitor and improve care and treatment at the hospital. Leaders had not identified that a culture of poor practice had developed.
- There had been significant changes in leadership between the December 2018 inspection and the May 2019 inspection. The registered manager had taken on the additional responsibility of regional manager. So, between January and May 2019, the manager was no longer solely based at Newbus Grange. When we carried out this inspection in June 2019, there was no registered manager working at the hospital and no regional manager. A new registered manager had been appointed but was yet to take up post, they were due to start a few days after our inspection. The service had a deputy manager and support from the regional team, which included a learning disability practice lead and a medical director.
- Staff told us their local leaders had always been visible and accessible at the hospital. They all described an open door style of management, where they could approach the previous manager whenever they needed to.
- To understand broader views about the leadership, we sought feedback from a number of external bodies. One clinical commissioning group, who were responsible for placing and funding a patient at Newbus Grange, told us that they had raised concerns with managers at the hospital because their patient's care plan had not been followed in recent months. They had also raised concerns, which whilst not directly concerning patient care, did concern management approaches to some staff behaviours. One issue related to a safeguarding concern the manager had not dealt with. They were concerned that since the manager had ceased to be based at the hospital, there was a lack of leadership, which resulted in their patient's care not being optimised. They had raised these issues with the hospital in the months preceding our inspection and again around the time of our inspection. They told us they had been assured by senior managers at the provider that the issues were being investigated.
- Another clinical commissioning group told us they had raised concerns with the manager and regional manager because actions agreed at routine patient review meetings in February and May 2019 had not been implemented as they should have been, resulting in delays delivering the treatment programme to their patients. They attributed the uncompleted actions to the multidisciplinary clinical team at Newbus Grange.
- Feedback from another clinical commission group was positive about the quality of care provided by Newbus Grange and noted similar positive views had been expressed by an independent professional who had visited their patient in recent months. Their only concern related to the bulky nature of patient documentation.

- The hospital had received a safeguarding assurance visit from one clinical commissioning group in April 2019, which did not identify any safeguarding concerns and was generally positive in terms of feedback to the hospital. However, following review of two patient records, the team had required Newbus Grange staff to ensure evaluation and review documentation was completed more effectively, patient involvement in care planning was more evident and mental capacity assessments were completed more robustly.
- All the clinical commissioning groups we received feedback from told us they visited their patients regularly, one noting their patients were visited once a week by either their community nurse or social worker, in addition to visits made for regular and routine patient review meetings.

Culture

- Concerns had been raised with us about the culture at Newbus Grange, so we asked specific questions to understand the culture and to understand what it was like to work there. We wrote to 16 people who had left within the previous six months, to agency staff and to all 85 of the staff who were employed at the time of this inspection. Two ex-members of staff, two agency staff and one current worker contacted us to share their views.
- Staff we spoke with during the inspection told us the culture was open and transparent. They felt confident to report any poor practice they witnessed and did not fear any retribution. Some staff told us they had reported issues of concern to the manager and the issues had been dealt with swiftly and appropriately. They told us they were encouraged to report poor practice. They were not worried or intimidated to report things and some said the provider had a "zero tolerance" to poor practice, which they felt was the right approach.
- Staff told us they wrote incident reports in their own words and had never been asked or told to change what they had written. One told us they had been asked by the manager to provide additional information about an incident that was being investigated but they had not been asked to change the content or meaning of what they had written.
- We saw evidence that staff reported incidences where they felt care or staff behaviours fell below the expected standard. Managers took action in all but one of these incidents, which was a safeguarding concern that had not been promptly reported to the local authority or dealt with in a timely manner. However, we found that incidents were not always reported effectively. There were discrepancies between what we viewed on CCTV footage and what staff had recorded on incident forms. We also found that managers had not identified when staff actions or lack of staff engagement with some patients could have directly affected patient behaviours which led to situations where restraint was required.
- Apart from one member of staff, who thought there were cliques of staff at Newbus Grange, all others said there were no such closed relationship groups at the hospital. They told us some of their colleagues socialised outside of working hours but most chose not to. The staff we spoke with said they kept their work and private lives separate. Most felt there was no negative impact because some colleagues chose to become friends but one told us that friends working together could be seen having more interactions with each other than with the patient they should be supporting.
- There was a Personal Relationships at Work Policy but this was out of date and due for review in September 2017. The policy was drawn up by the previous owners of the hospital, who ceased to be involved with the running in August 2018. Despite the policy being out of date, all staff we asked were familiar with the content. They could explain why it was important that staff who had a personal relationship, should not work together when providing direct engagement and observation for patients. Staff explained that, those colleagues who were in a personal relationship, needed to declare this to managers who would record it. One member of staff explained that managers could require one of the persons in the relationship to move to a different site to work if their relationship could be compromising. Staff knew which of their colleagues were in a personal relationship. We were told there were two couple relationships and no familial relationships working at the hospital when we carried out this inspection.
- All current staff were clear that everyone was required to undertake and complete the accredited conflict resolution training before working unsupervised at the hospital. Several staff noted that when the agency had supplied a worker who had not completed the required training, they had been sent home and had not been

permitted to work the shift. No one told us they felt unsafe at work because there were not enough staff trained to support them with conflict management and restraint.

- Staff who had raised issues of concern or issues in supervision were confident the information had been treated in confidence. None of the staff we spoke with were aware of managers inappropriately disclosing a confidence. None of the staff had heard confidential information being shared about staff working at other company sites.
- One current and two ex-members of staff told us they had not been suitably prepared for the role, two found it difficult dealing with the level of patient violence. One describing frequent attacks from patients, which they said if they had known was a risk, would have stopped them applying for the job.
- Two members of agency staff were concerned with the culture at Newbus Grange, alleging racial intolerances from permanent staff. Another member of staff alleged gender intolerances from a male colleague.
- An ex-member of staff told us that, whilst there were some really good staff working at Newbus Grange, some were not suited to work because of the stressful and difficult nature of it. They told us some staff intentionally antagonised patients so they could use restraint. They stopped working at the hospital because, when they were asked to work with a volatile patient, another member of staff asked them "how they were with their fists". This distressed them so they left. Staff still working at the hospital told us they were sure they would know if there was any abusive practice taking place at Newbus Grange, they had not witnessed any; and they would report it to managers or to the police if they discovered any. However, we found that there was poor practice, which had gone undetected and unchallenged by staff and managers. The poor practice we described earlier is indicative of an unhealthy culture, where staff fail to recognise and report things that negatively impact on patients.

Governance

- The delivery of high quality care was not assured by the leadership, governance or culture of the hospital.
- Managers had carried out routine weekly audits and analysis of the CCTV footage. There was a process and up to date company policy for supporting them to do this. Audits of this nature had recently led to the discovery of poor staff practice resulting in a staff dismissal and a police investigation. However, managers had failed to identify that incident reports did not always match the CCTV evidence of what had occurred prior to or during episodes of restraint. Had this taken place more effectively, poor staff behaviours and practice would have been evident to managers.
- We looked at 45 of these audits during our inspection. We found that managers had identified poor practice three instances. It was clear what they had done about this in two of the cases. One showed a member of staff had left a file in a patient area and the manager had addressed the issue with them. One records limited engagement with a note to arrange supervision. However, one (after a member of staff alerted managers to a colleague using their mobile when they should have been carrying patient engagement and observation duties) did not reference what the manager planned to do with the information. We would expect to see an action to indicate that the poor practice would be addressed with the staff member.
- We found evidence of staff using poor body language and posture during our analysis of the CCTV footage. None of the audits we looked at identified this. Poor body language can have a negative impact on the person being restrained. It could in fact prolong or aggravate the incident. We would expect managers conducting the audits to identify any poor body language and work with staff to address it.
- Some of the audits showed that managers discussed the analysis with colleagues and updated patient care plans as a result of what they had seen and many referenced positive interactions between patients and staff, describing a range of activities they were supporting patients with.
- The provider did not monitor non-compliance with supervision effectively, which meant that some staff were not supervised at all between January and 1 June 2019. We found that 10 staff had not received any recorded supervision during this period, all but one of whom had worked shifts during the period. For May 2019, 37 staff were due for supervision but only 16 had received it.
- The staff supervision matrix was not up to date. The copy we saw had hand written ticks and dates written alongside or over the printed colour coded boxes which should have identified when a supervision had taken place. Three staff were not showing on the matrix. They

had had been working at the service for at least two months. During this time, one had received four supervision sessions and the other two had received one each, but the matrix had not been updated to reflect this. In the seven staff files we looked at, supervision records were not always completed in line with what was recorded on the matrix or the written supervision record was missing.

- All of the staff we spoke with told us they were able to request and receive supervision quickly when they asked for it, even if they were working a night shift. One told us the manager would often stay late into the evening to ensure they saw night staff. They felt the supervision they received was beneficial and supportive.
- Whilst most staff received ad-hoc supervision, this was not planned and staff could be called upon without notice to have their supervision. The provider used one supervision template which to record a variety of different types of supervision. It identified if the supervision was one to one, peer, staff meeting or formulation meeting. The quality of recording of supervision was poor. It was more a record of reminding staff of their contractual arrangements, for example in relation to the use of mobile phones at work. There was little evidence that support workers were given the opportunity to critically reflect or develop their practice. There was no evidence that nurses engaged in regular clinical supervision. The one file we looked at showed the nurse had not had any clinical supervision since February 2017. We were told nurses did not choose their clinical supervisor and did not prepare a supervision agenda in advance for their sessions.
- We were able to see that staff requested support or raised issues during their supervision but we were not able to determine what the supervisor would do in response. There was no evidence that managers audited supervision records to ascertain the quality or that they put measures in place to improve it for staff.
- Staff received an annual appraisal but when this took place, it was counted on the supervision matrix as a period of supervision.
- Staff had access to support for their own physical and emotional health needs through an occupational health service provided by the company.
- Two nurses told us they tried to get support workers to acknowledge the injuries they sustained at work and would ask them if they were ok.
- Staff had become accustomed to being assaulted and hurt, one describing it as “part of the job”. We would assert that staff routinely being assaulted and injured by patients should not be part of the job and the provider should work to reduce these occurrences.
- Both an ex-employee and several serving members of staff told us that they were often assaulted and injured by patients during the course of their work. The ex-employee described painful injuries that one patient was known to inflict, an injury that required time off work to recover from. We saw evidence of deep scratches and skin tears to the arms of one member of staff which had been inflicted by a patient. Staff told us there was a culture of not reporting these injuries.
- The provider did not effectively find out why staff left the service. Their analysis did not establish why staff left and why they had such high staff turnover rates (39% at the last inspection). Staff who no longer worked for the service told us they were given very little support to prepare them and enable them to safely carry out their roles and some felt unsafe.

Management of risk, issues and performance

- Managers had not conducted suitable audits of the environment to ensure they were providing accommodation which met with the individual preferences of the patients. They had not identified that three patients had no window coverings to limit the amount of light entering their bedrooms. No window coverings also meant that there was a risk to the privacy and dignity of the patients using those rooms. One of the bedroom windows had a frosted film applied to it but this merely obscured the view. None of the patients in these bedrooms could influence the amount of natural light entering their rooms. Unfiltered light into bedroom spaces can have a negative impact upon sleep hygiene and could influence how safe and comfortable patients feel in their environment.
- Managers had not conducted suitable audits to identify that an exposed window blind in a patient bedroom was safely housed. We had informed the registered manager in May that this posed a risk to patients but nothing had been done to rectify the issue in the intervening period between us telling them and our return inspection. The cord posed a risk of accidental or deliberate harm and was not removed until we raised it at this inspection.
- Following our inspection in May 2019, we informed the registered manager that we concluded there were a

number of restrictive practices taking place at Newbus Grange. These included the use of plastic crockery, access to patient areas such as the therapy kitchen and accessible bathroom, along with access to personal items such as electronic devices and bedroom keys. We noted that some patient bedrooms were bare, with limited or no personalisation. We had reviewed patient records and found there was insufficient documentation to justify these practices and we were not able to fully establish why these practices was in the patients' best interests. We explained this to the registered manager who told us they would supply us with the necessary documentation to provide this assurance. The information was never supplied to us. When we returned to carry out this inspection in June 2019, the same practices were evident and patient records had not been updated to justify why they were clinically necessary or in the patients' best interests. Managers had not used the intervening period to ensure that restrictive practices were individually assessed, clinically justified or in the best interests of patients. The provider did not carry out this work until after our inspection had taken place.

Information management

- Managers had not identified that a room used for family visits contained shelving with multiple patient folders stored on it, which clearly showed patient names on the spines. Some of these folders were empty but several contained patient information. The information related to one patient, showing their likes and dislikes for preferred activities. Whilst the information was not of a sensitive nature, allowing patient information to be freely accessible to visitors is poor practice with respect to information governance. Patients have the right to know their information is stored securely and organisations have a duty to store information securely.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Full information about our regulatory response to the concerns we have described will be added to a final version of this report, which we will publish in due course.

- The provider must ensure all staff have planned, relevant, regular and effective supervision, which is suitably recorded.
- The provider must ensure that patient bedrooms have suitable window coverings to ensure patients can regulate the amount of natural light entering their rooms.
- The provider must ensure that they carry out regular analysis of physical interventions involving restraint to ascertain what improvements can be made in relation to staff behaviours, including body language, to identify where additional staff training is required. The provider must ensure that the recording of incidents accurately reflects the incidents they relate to.
- The provider must ensure good governance with respect to the provision of high quality safe care and treatment. This good governance includes but is not limited to: identifying and meeting staff training needs; addressing poor practice; addressing patient assaults on staff; accurate reporting and recording of incidents; overall cleanliness of the building; analysis and action in relation to increased incidences of restraint; addressing cultural issues including allegations of discrimination based upon any protected characteristic.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that the environment remains free of unpleasant odours.
- The provider should continue to ensure that any restrictive practice is individually assessed and is clearly documented to reflect why the restriction is in the patient’s best interest.
- The provider should ensure they carry out due diligence with respect to pre-employment checks and ongoing performance management, to ensure all staff employed are suitable and remain suitable to work with patients.
- The provider should ensure that doors marked “keep closed” are kept closed.
- The provider should ensure the safe and confidential storage of all patient information.
- The provider should ensure that nurses are able to spend more time in patient areas, supporting and monitoring the running of the ward area.
- The provider should ensure they carry out effective analysis to understand why staff leave the service and use the information to improve staff retention.
- The provider should ensure they analyse the volume and intensity of assaults on staff and strive to improve this.
- The provider should ensure that new staff are given the support they need to prepare them for the role.
- The provider should ensure that staff understand the importance of working within the parameters of positive behaviour support plans.

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 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good governance Systems and processes were not effective to ensure the provision of high quality safe care and treatment. 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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing Staff supervision systems and processes were not effective. The provider had not ensured that staff had access to sufficient and effective supervision, relevant to their role. The provider had not identified that their supervision matrix was out of date. The provider had not identified when staff behaviours and body language was an indicator that they needed additional training. This was a breach of regulation 18 (2) (a)(c)

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

This section is primarily information for the provider

Requirement notices

The use of physical restraint had risen sharply. Staff involved in restraint were seen demonstrating unhelpful and uncaring behaviours which could be seen as provocative and could prolong episodes of restraint.

This was a breach of regulation 12 (1) (2) (a,b,c)