Enbridge Healthcare Limited

# Magna House

**Inspection report**

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

| | |
|---|---|
| Overall rating for this location | Inadequate |
| Are services safe? | Inadequate |
| Are services well-led? | Inadequate |

# Summary of findings

## Overall summary

Our rating of this location went down. We rated it as inadequate because:

- Staff did not consistently record and report incidents in line with the provider's policy. Staff had not reported some incidents, including a small fire at the service, and the partial collapse of a bedroom floor.
- The service had failed to notify CQC of some reportable incidents involving the Police.
- Some patients told us they had experienced physical assaults by staff.
- The hospital was not clean. Some patient bedrooms were cluttered with personal belongings, food, drinks, dirty crockery and rubbish.
- The provider had failed to address maintenance issues and repairs in a timely way, leaving areas of risk to some patients, including ligature risks.
- Staff had not followed best practice following administration of rapid tranquillisation with the monitoring and recording of physical observations in care records.
- There were not enough registered mental health nurses on shift across the hospital to consistently meet the needs of the patients in a safe and timely way.
- Not all staff had been trained or updated with training around the management of violence and aggression.
- There had been a high number of patient assaults on staff. Staff we spoke with had been left unsupported following such incidents.
- Staff had not updated individual patients risk assessments following incidents to reflect current risks and management of these risks.
- Not all staff adhered to the providers infection prevention and control policy.
- Staff did not adhere to the Mental Health Code of Practice (CoP) during an incident of seclusion.
- Patients told us that not all staff treated them with kindness and compassion. Some patients told us that staff did not always interact with patients while they were on enhanced observations. We heard of occasions when staff had been speaking to one another in front of the patients, in a language other than English.

However:

- Staff told us that staffing overall had improved over recent months.
- All staff we spoke with told us that the hospital director and deputy hospital director were visible across the service, and accessible.
- Some patients and carers we spoke with were positive about some of the staff team.
- The provider kept an updated log of all safeguarding concerns reported to the Local Authority with commentary on actions taken or outstanding.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Acute wards for adults of working age and psychiatric intensive care units** | Inadequate  | Our rating of this service went down. We rated it as inadequate because:<br>• Cleaning systems in place were ineffective. The wards were unclean in most areas. We saw unclean ward kitchens and appliances, dirty and stained flooring, unclean toilet and shower areas, unclean windows, and unclean bedrooms.<br>• The wards had ongoing maintenance issues and urgent repairs were required. We saw that damage to property had left areas of risk to some patients, including ligature risks.<br>• The ligature assessment for Aspen ward had minimal mitigations in place and was not comprehensive. The provider previously described this ward as rehabilitative. We were not assured that managers had updated the ligature risk assessment to reflect the current patient group.<br>• The hospital did not have enough registered mental health nurses to ensure care given was safe and timely to patients on the acute wards.<br>• Staff had not always assessed and managed risks effectively. Individual patient risk assessments were not accurate despite staff having reviewed these.<br>• Not all incidents which required reporting had been. The partial collapse of a bedroom floor had not been recorded. Staff failed to capture full incident details within incident forms or in patient clinical notes.<br>• A registered staff member we spoke with told us that they have never used seclusion across the hospital. Yet we were aware of a seclusion in the cottages earlier this year.<br>• Not all staff had been trained or updated with training around the management of violence and aggression. There had been a high number of patients assaulting staff.<br>• Not all staff adhered to the providers infection prevention and control policy.<br>However, |

# Summary of findings

- Staff told us that staffing overall had improved over recent months.
- All staff we spoke with told us that the hospital director and deputy hospital director were visible across the service, and accessible.
- Some patients and carers we spoke with were positive about some of the staff team.
- The provider kept an updated log of all safeguarding concerns reported to the Local Authority with commentary on actions taken or outstanding.

## Long stay or rehabilitation mental health wards for working age adults

**Inadequate**

Our rating of this service went down. We rated it as inadequate because:

- The hospital did not have enough registered mental health nurses to ensure care given was safe and timely.
- Cleaning systems in place were ineffective. The wards were unclean in most areas. We saw unclean ward kitchens and appliances, dirty and stained flooring, unclean toilet and shower areas, unclean windows, and unclean bedrooms.
- Staff had not always assessed and managed risks effectively. Individual patient risk assessments were not accurate despite having been reviewed by staff.
- Not all incidents which required reporting had been, in line with provider policy. This included a small fire.
- Staff had not followed best practice following administration of rapid tranquillisation. Records were not comprehensive.
- A registered nurses we spoke with failed to recognise that an incident that had occurred was seclusion.
- The wards had ongoing maintenance issues and urgent repairs were required. We saw that damage to property had left areas of risk to some patients, including ligature risks.
- The clinic room fridge was displaying as under the optimum temperature. Daily fridge temperatures checked by staff indicated this had been ongoing since the beginning of April 2023.
- Not all staff had been trained or updated with training around the management of violence and aggression. There had been a high number of patients assaulting staff.

# Summary of findings

- Not all staff adhered to the providers infection prevention and control policy.
- Patients told us that not all staff treated them with kindness and compassion. Some patients told us that staff did not always interact with patients while they were on enhanced observations. We heard of occasions when staff had been speaking to one another in front of the patients, in a language other than English.

However:

- Staff told us that staffing overall had improved over recent months.
- All staff we spoke with told us that the hospital director and deputy hospital director were visible across the service, and accessible.
- Some patients and carers we spoke with were positive about some of the staff team.
- The provider kept an updated log of all safeguarding concerns reported to the Local Authority with commentary on actions taken or outstanding.

# Summary of findings

## Contents

# Summary of this inspection

## Background to Magna House

Magna House is a 29-bed independent hospital in Lincolnshire, providing care, treatment and rehabilitation services to people who are experiencing mental health issues. It registered with the Care Quality Commission in August 2020 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 comprises of one 11 bedded male acute ward (Redwood ward) and four cottages. Aspen ward, one of the cottages had changed its function since our last inspection in October 2022. It is now a 7-bed female acute ward, (it was rehabilitative).

The rehabilitation wards consist of Beech 1, a 5 bedded female ward; Beech 2 a three bedded male ward and Beech central has a further 3 beds, which can accommodate either 3 males or 3 females.

All bedrooms have ensuite bathrooms. Wards in each of the cottages are located on the ground floor, and Redwood ward is over two floors, in a separate building.

The hospital has recently built a further 8 bedded female acute ward which they hope to open later in 2023.

Magna House has a registered manager. It was first inspected in June 2021, when only the cottages were open and in use, and was rated as good overall with requires improvement for Safe. In July 2021 the CQC undertook an urgent, unannounced and focused inspection due to concerns about a newly opened ward (Redwood). This resulted in CQC serving a notice of decision imposing conditions on the providers registration, which included not admitting any further patients to Redwood ward without CQC written approval. The provider completed an action plan, and the conditions were removed following a further unannounced, focused inspection in May 2022.

We undertook a further, full inspection of Magna House in October 2022. We found the provider to be in breach of the Health and Social Care Act (regulated activities) Regulations 2014: Regulation 12 - safe care and treatment; Regulation 15 – premises and equipment; Regulation 9 – Person-centred care; Regulation 18 – Staffing; Regulation 17 – Good governance and Regulation 10 – Dignity and respect. We served Requirement notices and subsequently received an action plan from the provider which they continue to work through.

We undertook this unannounced, focused inspection following concerns bought to our attention through provider statutory notifications, and through concerns and feedback received from members of the public, patients, the Integrated Care Board, and the Police.

Following this inspection we made a referral to environmental health due to concerns around cleanliness and food hygiene and storage on the wards. We were also concerned about the safety of the structure of the new ward following the partial collapse of a ceiling. Therefore we made a referral to the Health and Safety Executive.

The provider had received a Fire Safety Order from the fire service, following a fire at the hospital at the end of 2022. The provider continue to adhere to actions stipulated within this and have an ongoing action plan in place.

# Summary of this inspection

We did not examine every key question. The two key questions we examined were Safe and Well-led. We focused upon areas of concern and therefore did not inspect all key lines of enquiry.

**What people who use the service say**

We spoke with 7 patients who were receiving care and treatment at Magna House; 1 patient who had recently received care and treatment at Magna House, and six carers of patients presently using the service.

Of the 6 current patients we spoke with, three told us that staff had physically assaulted them. One patient who had been discharged from the service also reported being physically abused by staff. We bought this to the attention of the Nominated Individual and the Registered Manager. The Registered Manager took immediate action for the alleged assaults they were unaware of, spoke with the patients concerned, completed referrals to the Local Authority as appropriate and started investigations.

Two patients and one carer told us they had witnessed staff speaking to one another in a language other than English when caring for patients, and that staff failed to interact with patients when they are on their enhanced observations. A further 1 patient told us that “only some staff speak to me”.

Two patients told us the environment was not clean. One patient said staff only clean the bathroom areas twice each month.

Three patients talked about areas of the ward needing repairs, examples given included a boarded-up glass panel on one ward, loose, exposed plaster on a wall, and a radiator that needed replacing after it had been pulled off of a wall.

Positively, 4 out of five carers told us that they felt their relatives were safe at Magna House, and complemented some staff members, using terms such as “welcoming”: “lovely” “kind”, “helpful” and “efficient”.

Two patients told us that the food provided was poor with a lack of choice.

Two patients told us there was a lack of activities and “not much to do”.

## How we carried out this inspection

This was a focused inspection and looked at two key questions: Safe and Well Led. We did not examine all key lines of enquiry. We focused upon concerns which had been raised.

The inspection team consisted of two CQC inspectors and one expert by experience. An operations manager supported the inspection remotely.

The inspection team carried out the following activities during the inspection:

Spoke with 7 patients who were using (or had used) the service.

Spoke with 6 carers of those who were using the service.

Interviewed 6 staff to include patient safety officers: support workers (regular and agency) and registered nurses.

# Summary of this inspection

Spoke with the hospital director, deputy director, the Nominated Individual, the Head of Operations and the chef.

Reviewed 22 incidents forms staff had completed during April 2023.

Explored the management of 7 specific incidents which had been reported to us either by the provider or external sources.

Completed a review of an incident of seclusion.

Reviewed records of 5 incidents of rapid tranquillisation records for 2 patients.

Reviewed maintenance logs.

Undertook a tour of the hospital.

Reviewed a range of documents and polices relating to the running of the hospital.

Reviewed 4 individual patients risk assessments.

Undertook a review of reported safeguarding and outcomes in 2023.

## Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the service MUST take to improve**:

- The service must ensure all staff receive breakaway training before working shifts on the wards.
- The service must ensure that agency staff used are trained in the same techniques for the management of violence and aggression as substantive staff.
- The service must ensure that immediate action is taken if the medicines fridge is recording a temperature which may affect medicines proficiency.
- The service must ensure all staff adhere to their infection prevention and control policy.
- The service must ensure they have a robust incident reporting and recording system in place which is monitored by senior staff.
- The service must ensure CQC are informed of all reportable incidents.
- The service must ensure staff escorting patients on leave observe and interact with them.
- The service must ensure that all staff are aware of the provider seclusion policy and adhere to the Mental Health Act (1983) Code of Practice.
- The provider must ensure a comprehensive assessment of ligature risks across the hospital is undertaken.
- The provider must undertake a review of cleaning and infection control practices.
- The provider must ensure acceptable food hygiene procedures are in place across the hospital.
- The provider must ensure maintenance staff are employed who respond to concerns and repairs in a timely way.

# Summary of this inspection

- The provider must ensure there are enough Registered Mental Health Nurses on each shift to meet the needs of patients.
- The provider must ensure a competent professional maintains oversight of rapid tranquillisation administration and monitoring.
- The provider must ensure that de-briefs following incidents of violence and aggression are undertaken and recorded in a timely way.
- The provider must ensure they devise and implement effective systems to ensure patients risks assessments are accurate, reviewed as appropriate and updated regularly.
- The provider must ensure staff take appropriate actions and assessments in the event of a patient fall.

**Action the service SHOULD take to improve:**

- The service should aim to reduce the number of restrictive interventions.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Acute wards for adults of working age and psychiatric intensive care units** | Inadequate | Not inspected | Not inspected | Not inspected | Inadequate | Inadequate |
| **Long stay or rehabilitation mental health wards for working age adults** | Inadequate | Not inspected | Not inspected | Not inspected | Inadequate | Inadequate |
| **Overall** | Inadequate | Not inspected | Not inspected | Not inspected | Inadequate | Inadequate |

# Acute wards for adults of working age and psychiatric intensive care units

Inadequate

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

## Is the service safe?

Inadequate

We did not inspect all key lines of enquiry.

Our rating of safe went down. We rated it as inadequate.

### Safe and clean care environments

**Redwood and Aspen wards were not clean, well equipped, well maintained and fit for purpose.**

### Safety of the ward layout

Staff had completed ligature risk assessments of all wards areas but had failed to remove or reduce all risks identified. We viewed the ligature risk assessment for Redwood ward. We could not be sure who completed this as this was not stipulated. The assessment was dated March 2022 and had been reviewed in September 2022. It had pictures of potential ligature points which staff could refer too, along with mitigations in place to reduce risks. We did not feel that the assessment reflected all current risks, resulting from observed damage to the environment. This included damage to cupboard / wardrobe doors and doorframes.

The ligature risk assessment for Aspen ward was not as comprehensive, having no pictures. The assessment was undated. Whilst it identified ligature risks, there was insufficient mitigation. We did not feel that the assessment reflected all current risks, particularly as the nature of this ward was previously rehabilitative.

Ward areas were not clean and not well maintained. Managers had failed to ensure that the wards were clean. We saw areas on the ward which were dirty. This included but was not limited to unclean ward kitchens and appliances, dirty and stained flooring, unclean toilet and shower areas, unclean windows, and unclean bedrooms.

We saw that the wards had a dedicated cleaning schedule, which was ineffective. The hospital had a “day and night” cleaning job list, which the patient safety officers oversaw. Following inspection, we requested the cleaning schedule for the wards. We received the template as opposed to evidence that staff had cleaned the wards on a regular basis.

Not all staff followed the providers infection control policy despite having patients who had tested positive for Covid-19. There was no specific signage regarding infection prevention and control and no hand gel available upon entrances to the wards. Not all staff were bare below the elbow, and we saw some staff with nail varnish. The provider did not have a specific policy with regards to the management of Covid-19. They did have a Covid-19 risk assessment, which managers had reviewed in April 2023. This shared national guidelines around personal protective equipment; social distancing; testing, isolation and reporting procedures for staff and patients. It did not reflect that the hospital had numerous Covid positive cases or specific guidance around how to minimise the spread of this.

# Acute wards for adults of working age and psychiatric intensive care units

Inadequate

We reviewed some of the provider infection control audits undertaken on Redwood and Aspen wards between January and March 2023. On Redwood ward the score of these audits were 99% compliant. The identified non-compliant area highlighted was that not all carpets and flooring were intact, clean and free from stains. Staff had written that the bathroom floor was stained. This was the audit finding in all three months reviewed in January, February and March 2023. No actions had been taken to address this.

Staff who completed the infection control audits for Aspen ward scored 97% - 98%. Identified non-compliant areas included furniture having rips or tears (sofa in lounge), and carpets, flooring not being intact, clean, free from stains. Staff continued to identify and record these issues between January and March 2023. The auditor did not specify what areas of flooring were unclean or not intact. No actions had been taken to address this.

## Safe staffing

**The service did not have enough registered mental health nurses to keep people safe from avoidable harm.**

## Nursing staff

Across the hospital at the time of inspection, the service employed 4 registered mental health nurses (RMNs) and five registered general nurses (RGNs). Managers assured CQC that Redwood ward always had a dedicated RMN on duty throughout the 24-hour period. However, as there was not always a RMN working across Aspen and Beech wards, the RMN in charge of Redwood ward was having to carry out functions that a RGN could not undertake. For example, if a detained patient from Aspen or Beech wards requested to use their prescribed section 17 leave, the RMN from Redwood ward had to communicate with the staff, assess the patient and approve or deny the leave as being safe and appropriate. If there were occasions when staff on Aspen or Beech wards required urgent assistance during an incident, the RMN may have had to attend. If an informal patient was insistent on leaving the hospital, and staff did not deem this safe, the RMN would have to attend quickly to hold the patient formally and legally in the hospital, pending formal assessment by a psychiatrist. This arrangement was not safe. The provider reported that they had 4 registered nurse vacancies which they were recruiting into.

The hospital had no vacancies for support workers. Due to the high number of patients requiring enhanced observations, the hospital was using bank and agency staff to ensure observations were covered. Bank and agency staff worked across Redwood ward, Aspen and Beech wards as required throughout each shift. Between November 2022 and April 2023, bank and agency support workers had covered 1,410 shifts. This ranged from between 184 and 287 per month. To safely cover enhanced observations, the provider required between 6 and 9 additional support workers per shift during this 6-month period. During this time, the provider reported bank and agency staff could not fill 37 shifts. Supernumerary staff had filled 26 of these, which had left 11 unfilled shifts during this time. We could not be assured patients always received safe and timely care.

Managers had processes in place to support staff who needed time off for ill health. Managers told us that staff could seek additional support through human resources. Some staff told us that if they got injured at work, they would not be paid. Managers explained that this was considered on a case-by-case basis.

Levels of sickness over the last 6 months across the hospital had ranged between 4% and 6% month on month.

The staff turnover rate over the last 6 months across the hospital had ranged between 0% and 5%. The lowest month being December 2022 with 0%, and the highest reported in January at 4.9%.

# Acute wards for adults of working age and psychiatric intensive care units

Inadequate

## Mandatory training

Staff had completed and kept up to date with most of their mandatory training. Exceptions to this was training in the management of violence and aggression.

Training data from the service indicated that compliance with the care certificate training was 76%. The provider later acknowledged that this training data was inaccurate, due to how their system pulled it through and subsequently confirmed that compliance was at 80%. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

Not all staff we spoke with were confident with the management of violence and aggression, more specifically the physical restraint of patients, if required. Managers reported the overall compliance with this training was 63% across the hospital. 50 staff had completed and were up to date with this training. However, 29 staff were overdue, and 22 staff reported to be within the timeframe for completion of 12 weeks. Therefore, just over half of substantive staff had not been trained or were out of date with this training.

Of the 22 staff who were within timescales for completing, they had been employed by the service for between 13 and 33 days. Due to the high number of incidents, we were concerned that not all staff had the skills, training, and confidence to safely manage violence and aggression, which is unsafe for both patients and staff.

Additionally, we could not be clear if break-away training was part of the providers overall training in the management of violence and aggression, or if it was standalone training. We would expect staff to have received breakaway training before working on the wards. We viewed the initial one-week staff induction timetable. This did not include breakaway training. It consisted of four days of various training, followed by a day shadowing staff on their allocated wards.

## Assessing and managing risk to patients and staff

**Staff did not consistently assess, manage and record risks to patients and themselves well.**

Staff completed risk assessments for each patient on admission or shortly following admission, using a provider risk tool. We reviewed two risk assessments on Redwood ward. Staff had reviewed these regularly. We found they were not accurate, and staff had not updated these to reflect risks following incidents. We identified that there had been incidents of physical aggression towards staff and premises which staff had not reflected within the risk assessment. We also found that one patient had experienced three falls which did not feature in the risk assessment nor specific falls risk assessment. We found that one patient had consumed alcohol and had smoked in their bedroom, which staff had failed to record as expected. In a second risk assessment viewed, staff had failed to include a recent incident of restraint and deliberate self-harm.

## Use of restrictive interventions

We were not assured that staff avoided using restraint by using de-escalation techniques consistently due to poor staff recording on incident forms to reflect this. Not all incident forms or care records described the sequence of events which led to a restraint, including de-escalation or distraction methods staff used to try to avoid physical interventions.

We reviewed 2 incidents across Redwood and Aspen wards, which had involved restraint. Staff had not recorded every staff member involved in 1 restraint, nor had staff recorded on either form if there was any known or reported patient or staff injuries.

# Acute wards for adults of working age and psychiatric intensive care units

Inadequate

We requested incident data which we received across the whole hospital. Between November 2022 and April 2023 there had been a reported 817 incidents. The number ranged month on month, the lowest recorded was 85 (in April 2023), the highest recorded was 213 in January 2023. Numbers of reported incidents had increased since the last inspection of Magna House.

Of the 817 incidents reported, 197 of these had led to patient restraint. No patients had been restrained in the prone (chest down) position. Staff had administered rapid tranquillisation on 82 occasions between November 2022 and April 2023.

All staff we spoke with reported they had been subject to verbal or physical abuse from patients. Of the 817 incidents reported between November 2022 and April 2023, there had been 121 assaults on staff. These occurred monthly and ranged between 9 reported in January 2023, and the higher number of 30 reported in December 2022.

Agency staff used had been trained in a different method of restraint. We were concerned that potentially staff could be using two different types of restraint on patients. Staff we spoke with told us that agency staff would not get involved with restraint. We were concerned that both patients and staff could come to harm during incidents of physical aggression, either because agency staff would not intervene, or substantive staff who were untrained may try to assist.

## Safeguarding

**Staff received training on how to recognise and report abuse, appropriate for their role.**

Staff kept up to date with their safeguarding training. At the time of inspection, compliance rate with safeguarding training across the hospital was 94%.

Staff followed clear procedures to keep children visiting the ward safe. Staff arranged any visits in advance and ensured the visits were in a safe and private space.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. All staff told us they would escalate to the nurse in charge and / or the hospital director.

Between 18 November 2022 and 26 April 2023, the provider had raised 26 safeguarding concerns with the local authority. Of these, the provider completed formal investigations for 8 as requested. The provider found one of the 8 to be upheld in the cottages. This related to the inappropriate care and treatment of a patient. The staff member was subsequently dismissed.

The hospital director led and undertook investigations as the result of safeguarding concerns and made changes based on the outcomes. The hospital director kept a specific safeguarding log which was updated to reflect actions taken, investigations completed, outcomes and learning from these.

## Track record on safety

**The hospital had a variable track record on safety.** We were aware that the Police had attended the hospital on numerous occasions to assist staff with the management of violence and aggression on the acute wards. One patient also informed us of a structural issue with the building of the new ward (currently not open), which led to the partial collapse of part of a patient flooring in a bedroom on Redwood ward. Fortunately, the staff had moved the patient from

this bedroom as they had noted unstable flooring in this area. Therefore, no harm was caused to any patient or staff. We asked to view the incident form to review actions taken and any learning. We discovered that staff had not completed an incident form. Following the incident a structural engineer reviewed the building and confirmed it was safe for both patients and staff.

### Reporting incidents and learning from when things go wrong.

**Staff had not reported all incidents in line with provider policy.** We reviewed 6 incident forms from April 2023 for incidents across the acute wards. Staff did not complete incident forms comprehensively. Some lacked detail. For example, where staff had used restraint, they had not always recorded the methods used. Some incident forms did not indicate if there were any sustained or reported injuries to patients or staff. Staff had not always recorded if de-briefs had been completed. Of the 6 incident forms reviewed, staff had not recorded debriefs taking place or as being offered. Staff did not always transfer information about the incidents across to individual patient clinical notes. In addition to this we found that senior managers had not reviewed all incident reports. Of the 6 we reviewed; a senior manager had signed off 3.

## Is the service well-led?

Inadequate

We did not inspect all key lines of enquiry.

Our rating of well-led went down. We rated it as inadequate.

### Leadership

Staff said the registered manager was visible in the service and approachable for patients, staff, families, and visitors. The registered manager was responsible for overseeing all clinical care, infection control, housekeeping, maintenance, complaints, safeguarding, as well as undertaking internal investigations. We felt it was unrealistic to expect one manager to effectively oversee all these areas. We were pleased to learn that the provider had recently recruited a deputy hospital director who was in post at the time of inspection. There were no ward managers in post at the time of inspection.

The service has had several registered managers since registering with the Care Quality Commission, although the current manager had remained in post for over 12 months which had given some consistency.

### Culture

Not all staff felt supported. Some staff told us that they were afraid or reluctant to get involved with incident management, because if they got injured and needed time off work, they would not be paid. We raised this with senior staff who told us that this was reviewed on an individual basis. Staff also told us that de-briefs following incidents did not routinely happen, despite there being a process in place. We confirmed this through reviewing incident forms.

### Governance

# Acute wards for adults of working age and psychiatric intensive care units

Inadequate

**Our findings from the other key questions demonstrated that governance processes did not consistently operate effectively at team level.**

Staff undertook regular cleaning audits. However, areas of the hospital were dirty or in need of redecoration. Senior managers had failed to rectify this despite this being raised during our last inspection.

There were no maintenance team members at the time of inspection. Managers had been utilising some maintenance support staff from another service. We found numerous outstanding maintenance issues, some of which caused an immediate concern due to potential harm, such as broken door frames and a missing wardrobe door.

We did not feel that there was sufficient oversight of risk assessment and risk management. We found that although staff had regularly reviewed risk assessments, these were inaccurate. Incidents of concern recorded within clinical notes had not been referred to by reviewing staff.

We did not feel assured that the provider had adequate oversight of incident management. Staff had not always completed incident forms in line with provider policy. Incidents which should have been reported had not been. For example, a partial floor collapse of a bedroom. Staff were not consistently completing incident forms comprehensively. Some forms did not record the method of restraint used, patient or staff injuries, and there was a lack of consistent de-briefs recorded. In addition to this we found that senior managers had not reviewed all incident reports.

There was not a registered mental health nurse (RMN) available within each ward. The hospital was frequently staffed with one RMN on Redwood ward, but not on Aspen ward, nor on Beech wards. Registered general nurses often took charge of these areas. One RMN across the entire hospital was not adequate to meet patients' needs in a safe and timely way. The provider had a workforce plan in place to address staffing, but this was not in place or embedded to address the short falls of staff seen at the inspection.

# Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

## Is the service safe?

Inadequate

We did not inspect all key lines of enquiry.

Our rating of safe went down. We rated it as inadequate.

### Safe and clean care environments

**Wards described as cottages were not safe, not clean, well equipped, well maintained and fit for purpose.**

Ward areas were not clean and not well maintained. Managers had failed to ensure that the wards were clean. We saw areas on the wards which were dirty. This included but was not limited to unclean ward kitchens and appliances, dirty and stained flooring, unclean toilet and shower areas, unclean windows, and unclean bedrooms.

We saw that the wards had a dedicated cleaning schedule, which was ineffective. Following inspection, we requested the cleaning schedules for Beech wards. We received templates as opposed to evidence that staff had cleaned the wards on a regular basis.

### Safety of the ward layout

Staff had completed ligature risk assessments of all wards areas but had failed to remove or reduce all risks identified. Ligature risk assessments reviewed were undated and we could not ascertain who had completed these. The assessments listed ligature risks but lacked adequate mitigation. We were not assured that they had been updated to reflect damage to the environment which posed further potential ligature risks, for example, an exposed radiator.

### Maintenance, cleanliness and infection control

Ward areas were not clean and not well maintained. Managers had failed to ensure that the wards were clean. We saw areas on the ward which were dirty. This included but was not limited to unclean ward kitchens and appliances, dirty and stained flooring, unclean toilet and shower areas, unclean windows, and unclean bedrooms. We saw that there was what looked like blood splatter in one patient bedroom. It was later confirmed that it was blood and had been left on the walls for 20 days. We bought this to the immediate attention of staff.

We saw that the wards had a dedicated cleaning schedule, which was ineffective. The hospital had a “day and night” cleaning job list, which the patient safety officers oversaw. Following inspection, we requested the cleaning schedules. We received the template as opposed to evidence that staff had cleaned the wards on a regular basis.

# Long stay or rehabilitation mental health wards for working age adults

Inadequate

Not all staff followed the providers infection control policy despite having patients who had tested positive for Covid-19. There was no specific signage regarding infection prevention and control and no hand gel available upon entrances to the wards. Not all staff were bare below the elbow, and we saw some staff with nail varnish. The provider did not have a specific policy with regards to the management of Covid-19. They did show us a Covid-19 risk assessment, which managers had reviewed in April 2023. This shared national guidelines around protective personal equipment; social distancing; testing, isolation and reporting procedures for staff and patients. It did not reflect that the hospital had numerous Covid positive cases or specific guidance around how to minimise the spread of this.

We reviewed infection control audits completed by staff for Beech 1 ward between January and March 2023. The audit score was between 98% and 99%. The area recorded as non-compliant was not all floor surfaces were impermeable in three different rooms. Staff had continued to highlight this between January and March 2023. No indicated actions or plan to address stated.

The auditor had scored between 98% and 99% for infection control audits undertaken on Beech 2 ward between January and March 2023. The area recorded as non-compliance was not all carpets, flooring had been intact, clean and free from stains. Staff continued to identify these issues between January and March 2023, although the auditor did not specify what areas of flooring were unclean or not intact. A kitchen floor and one room were recorded, but no further details given.

### Clinic room and equipment

The clinic room fridge on the cottages was displaying as under the optimum temperature. Daily fridge temperatures checked by staff indicated this had been ongoing since the beginning of April 2023. Yet we found no evidence of any actions or escalation to managers. This fridge held patient medicines. We requested that staff take immediate action to rectify this and to clarify with the pharmacist if the medicines were safe to use. The registered manager later confirmed that the medicines were destroyed as a precaution, further medicines re-ordered, and the fridge subsequently was fixed.

### Safe staffing

**The service did not have enough registered mental health nurses to keep people safe from avoidable harm.**

### Nursing staff

Across the hospital at the time of inspection, the service employed 4 registered mental health nurses (RMNs) and five registered general nurses (RGNs). There was not always a RMN working across Aspen and Beech wards. The RMN in charge of Redwood ward was having to carry out functions that a RGN could not undertake. For example, if a detained patient from the cottages requested to use their prescribed section 17 leave, the RMN from Redwood ward had to communicate with the staff, assess the patient and approve or deny the leave as being safe and appropriate. If there were occasions when staff on the cottages required urgent assistance during an incident, the RMN may have to attend. If an informal patient was insistent on leaving the hospital, and staff did not deem this safe, the RMN would have to attend quickly to hold the patient formally and legally in the hospital, pending formal assessment by a psychiatrist. This arrangement was inadequate and not safe. The provider reported that they had 4 registered nurse vacancies which they were recruiting into.

The hospital had no support worker vacancies. Due to the high number of patients requiring enhanced observations, the hospital was using bank and agency staff to ensure observations were covered. Bank and agency staff worked

across the acute wards and the rehabilitation wards as required throughout each shift. Between November 2022 and April 2023, bank and agency support workers had covered 1,410 shifts. This ranged from between 184 and 287 per month. To safely cover enhanced observations, the provider required between 6 and 9 additional support workers per shift during this 6-month period. During this time, the provider reported bank and agency staff could not fill 26 shifts. Supernumerary staff had filled 26 of these, which had left 11 unfilled shifts during this time. We were not assured patients consistently received safe and timely care.

Managers had processes in place to support staff who needed time off for ill health. Managers told us that staff could seek additional support through human resources. Some staff told us that if they were injured at work, they would not be paid. Managers explained this would be considered on an individual case-by-case basis.

Levels of sickness over the last 6 months across the hospital had ranged between 4% and 6% month on month.

The staff turnover rate over the last 6 months across the hospital had ranged between 0% and 5%. The lowest month being December 2022 with 0%, and the highest reported in January at 4.9%.

### Mandatory training

Staff had completed and kept up to date with most of their mandatory training. Exceptions to this was training in the management of violence and aggression.

Training data from the service indicated that compliance with the care certificate training was 76%. The provider later acknowledged that this training data was inaccurate, due to how their system pulled it through and subsequently confirmed that compliance was at 80%. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

Not all staff we spoke with were confident with the management of violence and aggression, more specifically the physical restraint of patients, if required. Managers reported the overall compliance with this training was 63% across the hospital. 50 staff had completed and were up to date with this training. However, 29 staff were overdue, and 22 staff reported to be within the timeframe for completion of 12 weeks. Therefore, just over half of substantive staff had not been trained or were out of date with this training.

Of the 22 staff who were within timescales for completing, they had been employed by the service for between 13 and 33 days. Due to the high number of incidents, we were concerned that not all staff had the skills, training and confidence to safely manage violence and aggression, which is unsafe for both patients and staff.

Additionally, we could not find evidence if break-away training was part of the providers overall training in the management of violence and aggression, or if it was standalone training. We would expect staff to have received breakaway training before working on the wards. We viewed the staff induction timetable. This did not include breakaway training. It consisted of four days of various training, followed by a day shadowing staff on their allocated wards.

### Assessing and managing risk to patients and staff

**Staff did not consistently assess, manage and record risks to patients and themselves well.**

# Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff completed risk assessments for each patient on admission or shortly following admission, using a provider risk tool. We reviewed two risk assessments on Beech wards. Staff had reviewed these regularly. However, we found one which was not accurate and had some risks following incidents staff had not recorded. This included a detained patient running out of the hospital, and an incident of a patient engaging in deliberate self-harm which led to a general hospital admission for treatment.

We identified that 2 different patients, during escorted leave, had successfully taken numerous amounts of items from a shop without paying. We were concerned that this happened with a staff escort.

### Use of restrictive interventions

We were not assured that staff avoided using restraint by using de-escalation techniques consistently due to poor staff recording on incident forms and within individual patient records.

We reviewed 7 incidents across Beech wards, which had involved restraint. Of the 7, 4 did not record the type of restraint used, nor all names and positions of staff members involved. 3 incident forms did not indicate if there was any known or reported patient or staff injuries.

We requested incident data which was provided for the whole hospital. Between November 2022 and April 2023 there had been a reported 817 incidents. The number ranged month on month, the lowest recorded was 85 (in April 2023), the highest recorded was 213 in January 2023. The number of incidents had increased since the last inspection of Magna House.

Agency staff used had been trained in a different method of restraint. We were concerned that potentially staff could be using two different types of restraint on patients. Staff we spoke with told us that agency staff would not get involved with restraint. We were concerned that both patients and staff could come to harm during incidents of physical aggression, either because agency staff would not intervene, or substantive staff who were untrained may try to assist.

All staff we spoke with reported they had been subject to verbal or physical abuse from patients. Of the 817 incidents reported between November 2022 and April 2023, there had been 121 assaults on staff. These occurred monthly and ranged between 9 reported in January 2023, and the higher number of 30 reported in December 2022.

Of the 817 incidents reported, 197 of these had led to patient restraint. No patients had been restrained in the prone (chest down) position. Staff had administered rapid tranquillisation on 82 occasions.

Staff did not follow NICE guidance and did not consistently adhere to the provider's policy when using rapid tranquilisation. We reviewed 5 rapid tranquillisation records involving 2 patients across Beech wards. We found staff had completed rapid tranquillisation records. However, the notes and corresponding clinical notes lacked detail in each episode we reviewed.

In one record, staff had taken a patient's blood pressure and recorded this as being very low, which required escalating to medical staff. We saw no evidence that staff had escalated, and furthermore, staff did not record the patients' blood pressure again for almost 5 hours. Within the individual patient care record, staff had not recorded the dose of medicines administered; observations of the patient breathing and / or colour when asleep, or if the patient had refused to have physical observations completed at any time. Post administration staff had not recorded any reflections with the patient or if any de-escalation had been needed.

In a second record viewed, staff recorded that the patient had refused to have physical observations undertaken. Staff had failed to record any observations from a distance, such as rate of breathing, levels of alertness, colour of patient. Staff had not recorded the dose of medicines administered, nor any post administration care or reflections carried out. Staff had recorded that the patient had engaged in deliberate self-harm prior to administration. Details, such as how the patient did this, and the severity of the incident was not present.

In a third record reviewed, staff had recorded that the patient had tried to engage in deliberate self-harm, but with a lack of detail relating to the severity of the incident. Staff recorded they used physical restraint, but clinical notes did not state type of restraint used and what staff took what position.

In the fourth record reviewed, staff had completed physical observations three times in the space of 45 minutes. Staff then recorded that the patient went out on leave. Staff did not record the patient's oxygen saturation levels at this time or a reason for not doing so. The clinical notes did not evidence any consideration of the patient going on leave so shortly after staff had given rapid tranquillisation. There were no records of the incident within the clinical notes.

In the fifth record reviewed, staff had administered rapid tranquillisation following deliberate self-harm. Staff had recorded the medicines given but had not recorded the site of injection. Staff recorded physical observations on three occasions within the first hour and had not given a rationale for discontinuing these at this point.

The hospital does not have a seclusion room. Staff had used seclusion on one occasion in March 2023 and had failed to keep clear records and follow best practice guidelines. Staff entries in clinical notes did not recognise this incident as seclusion. Therefore, staff did not adhere to the Mental Health Act Code of Practice to safeguard the patient. The entry in the patients' clinical records was not detailed and did not capture all details. We spoke with 2 registered nurses during the inspection, and they had not recognised the incident as seclusion. Neither nurse was aware of the provider seclusion policy.

## Safeguarding

**Staff received training on how to recognise and report abuse, appropriate for their role.**

Staff kept up to date with their safeguarding training. At the time of inspection, compliance rate with safeguarding training across the hospital was 94%.

Staff followed clear procedures to keep children visiting the ward safe. Staff arranged any visits in advance and ensured the visits were in a safe and private space.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. All staff told us they would escalate to the nurse in charge and / or the hospital director.

Between 18 November 2022 and 26 April 2023 the provider had raised 26 safeguarding concerns with the local authority. Of these, the provider completed formal investigations for 8 as requested. The provider found one of the 8 to be upheld. This related to the inappropriate care and treatment of a patient. The staff member was subsequently dismissed.

During the inspection, one former patient and two current patients on Beech wards told us that they had been physically assaulted by staff during their stay at Magna House. We bought this to the attention of the provider, who was

aware of one and had investigated at the time it was reported. The outcome was not upheld. The current patients who disclosed alleged assaults had not reported these to the provider previously. The registered manager took immediate action, spoke with the patients involved, commenced investigations, and reported these as concerns to the local authority. The provider has since informed us that none of these allegations had been upheld.

The hospital director led and undertook investigations as the result of safeguarding concerns and made changes based on the outcomes. A specific safeguarding log was kept and was updated regularly to reflect actions taken, investigations completed or pending and shared learning from these.

### Track record on safety

**The hospital had a variable track record on safety.** We were aware that the Police had attended the hospital on numerous occasions to assist staff with the management of violence and aggression on Beech wards. The managers had not ensured that staff recorded a fire incident that occurred in November 2022. The CQC were informed of this by the fire service, who had been called to attend and who subsequently issued the service with a Fire Safety Order.

We identified 4 incidents which staff had reported to the Police, for which the provider did not submit Statutory Notifications to CQC. These incidents occurred in September and October 2022. Two of these related to missing patients, one related to a patient trying to abscond and was displaying aggression to staff, and one related to a patient assaulting staff. We asked the hospital director about each of these incidents and found that staff had not logged three of these on incident forms. Therefore, senior managers were unaware of the incidents. On one occasion the Police were due to attend, but staff informed them they had the situation under control and therefore advised the Police they were no longer needed. The provider advised this particular incident had not been reported to CQC as the Police had not actually attended the hospital and was therefore not a requirement.

### Reporting incidents and learning from when things go wrong.

**Staff had not reported all incidents in line with provider policy.** We reviewed 16 incident forms in April 2023 for incidents across Beech wards. Staff did not complete incident forms comprehensively. Some lacked detail. For example, where staff had used restraint, they had not always recorded the methods used. Some incident forms did not indicate if there were any sustained or reported injuries to patients or staff. Staff had not always recorded if de-briefs had been completed. Of the 16 incident forms reviewed, staff had recorded 6 debriefs had taken place or had been offered.

Staff did not always transfer information about the incidents across to individual patient clinical notes. In addition to this we found that senior managers had not reviewed all incident reports. Of the 16 we reviewed; a senior manager had signed off 6.

## Is the service well-led?

Inadequate

We did not inspect all key lines of enquiry.

Our rating of well-led went down. We rated it as inadequate.

### Leadership

# Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff said the registered manager was visible in the service and approachable for patients, staff, families and visitors. It was evident that the registered manager was responsible for overseeing all clinical care, infection control, housekeeping, maintenance, complaints, safeguarding, as well as undertaking internal investigations. We felt it was unrealistic to expect one manager to effectively oversee all these areas. We were pleased to learn that the provider had recently recruited a deputy hospital director who was in post at the time of inspection. The service had no ward managers in place.

The service has had several registered managers since registering with the Care Quality Commission, although the current manager had remained in post for over 12 months, which had provided some consistency.

## Culture

Not all staff felt supported. Some staff told us that they were afraid or reluctant to get involved with incident management, because if they got injured and needed time off of work, they would not be paid. We raised this with senior staff who told us that this would be reviewed on an individual basis. Staff also told us that de-briefs following incidents did not routinely happen, despite there being a process in place. We confirmed this through incident reviews completed.

Patients told us that not all staff treated them with kindness and compassion. Some patients told us that staff did not always interact with them while they were on enhanced observations. We heard of occasions when staff had been speaking to one another in front of the patients, in a language other than English.

## Governance

**Our findings from the other key questions demonstrated that governance processes did not consistently operate effectively at team level.**

Staff undertook regular cleaning audits. However, areas of the hospital were dirty or in need of redecoration. Senior managers had failed to rectify this despite this being raised during our last inspection.

There were no regular maintenance team members at the time of inspection. Managers had been utilising some maintenance support staff from another service. We found numerous outstanding maintenance issues, some of which caused an immediate concern due to potential harm, such as broken door frames and peeling plaster. One patient had been waiting over a week to have a lightbulb in their ensuite replaced.

There was not a robust audit of rapid tranquillisation records. We found several examples of patients who had received rapid tranquillisation, yet staff had not recorded all details in line with best practice, had not consistently recorded physical health observations, and had not always sought further advice as appropriate regarding physical observations.

We did not feel that there was sufficient oversight of risk assessment and risk management. We found although staff had regularly reviewed risk assessments, these were inaccurate. Incidents of concern recorded within clinical notes had not referred to by reviewing staff within individual risk assessments.

# Long stay or rehabilitation mental health wards for working age adults

Inadequate

We did not feel assured that the provider had adequate oversight of incident management. Staff had not always completed incident forms in line with provider policy. Incidents which should have been reported had not been. This included a small fire and incidents reported to the Police. Staff were not consistently completing incident forms comprehensively. Some forms did not record the method of restraint used, patient or staff injuries, and there was a lack of consistent de-briefs recorded. In addition to this we found that senior managers had not reviewed all incident reports.

There was not a registered mental health nurse (RMN) available within each ward. The hospital was frequently staffed with one RMN on Redwood ward, but not on Aspen ward, nor on Beech wards. Registered general nurses often took charge of these areas. One RMN across the entire hospital was not adequate to meet patients' needs in a safe and timely way. The provider had a workforce plan in place to address staffing, but this was not in place or embedded to address the short falls of staff seen at the inspection.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The service did not ensure all staff received breakaway training before working on the wards.<br><br>The service did not ensure that agency staff used were able to assist in restraint as they had received different training to regular staff.<br><br>The service failed to take action when the medicines fridge was recording a temperature which could affect medicines proficiency.<br><br>Not all staff adhered to the providers infection prevention and control policy.<br><br>Staff had failed to explore why a patient had experienced three separate falls. |

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Ligature risk assessments were not robust, did not identify all risks, and had insufficient mitigations.<br><br>The hospital was unclean. Staff did not consistently adhere to infection prevention and control policies and procedures.<br><br>Staff had not adhered to the Mental Health Code of Practice during an episode of seclusion.<br><br>Staff did not follow best practice when administering rapid tranquillisation.<br><br>The service did not ensure staff accurately updated individual patient risk assessments during routine review. |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The service did not have robust incident management in place. Not all incidents which required reporting internally and externally had been reported. Incident forms did not always capture all details.<br><br>The service failed to ensure that de-briefs were routinely undertaken following incidents involving violence and aggression.<br><br>The hospital had numerous damage to the environment which had not been made safe or fixed which could result in harm. |

This section is primarily information for the provider

# Enforcement actions

The service did not ensure there were enough Registered Mental Nurses across the hospital on each shift to provide safe care and treatment.