Cygnet (OE) Limited

Cygnet Wast Hills

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 effective?	Inadequate
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

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

- To meet peoples' needs there were areas of improvement required despite the provider having made some changes since our last inspection. Those changes were new and still needed to be embedded.
- Not all areas of the hospital provided a well-maintained environment which met peoples' sensory and physical needs, although the provider had commenced a programme of environmental improvements. The hospital was not always clean and there were risks in the environment for people that the provider had not identified.
- There were omissions in applying the Mental Health Act when prescribing medicines and we also found one patient had been administered a dose of medicine to control behaviour in excess of their prescribed dose on two occasions. The provider had stored out of date oxygen in the clinic, this was not labelled to indicate that staff should not use this. Nurses had access to clinics and could have accidentally used this in an emergency.
- Physical health records were not always up to date, physical health observations were not recorded properly and had not been completed regularly. Several families had concerns about their family member's weight and records indicated that weight was not always well managed by staff. Staff did not always weigh people and record this when they should have done.
- Staff did not always keep care records up to date and accurate, there were omissions and inaccuracies, and information was not always easy to locate in the care records system used.
- People did not always receive active, goal-orientated treatment. The provider had improved activity but there was further work to be done. People did engage in activity, but a number of people were sleeping excessively or had irregular sleep routines. We did not think there was enough meaningful activity for people seven days a week and this did not prepare them well for discharge.
- There were ineffective governance processes. Leaders did not have oversight of all areas; not all local audits were effective and had not provided assurance in all areas. This meant that there were new concerns that required improvement that leaders were not aware of.

However:

- The provider had increased staff on shift to meet peoples' needs and although the service relied on agency support workers, they ensured that these staff were familiar with the service.
- Risk management had improved; Staff completed high level observations in line with policy, incidents were reported and investigated. Staff monitored physical health after episodes of self-harm and had improved some aspects of medicines management. Staff were trained, supervised, and appraised.
- Staff had completed annual health reviewed for all patients. Staff had recorded in patients' care records that they had access to dental, chiropody and opticians reviews and electrocardiograms had been carried out.
- All staff spoke highly of leaders and told us the culture was open and supportive. They followed good practice with respect to safeguarding and minimised the use of restrictive practices. Staff had the skills required to support peoples' care, treatment, and support plans, these reflected their sensory, cognitive, and functioning needs.

Summary of findings

- People cared for at the hospital told us that they felt safe and overall families said that staff were kind and compassionate. One parent now attended monthly clinical governance meetings. However, families provided mixed feedback about the level of activity on offer.
- People had clear discharge plans in place to support them to return home or move to a community setting. Staff worked well with services that provide aftercare to ensure people received the right care and support after they went home.

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

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 summary in the earlier part of this report.

Summary of findings

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Summary of this inspection

Background to Cygnet Wast Hills

Cygnet Wast Hills is an independent hospital providing assessment, treatment, and care to people with a complex learning disability and autism. It is managed by Cygnet (OE) Limited. The site has three units, Main House, Annexe, and Lodge. The hospital is in a rural area close to the outskirts of Birmingham. However, it is not within easy reach of the local community.

There are 25 beds: 15 in the Main House, six in the Annexe and four at the Lodge. However, at the time of our inspection there were 12 people admitted. There were two patients who were subject to Deprivation of Liberty Safeguarding and ten patients who were detained under the Mental Health Act. There were eight patients in the Main House, two in the Annexe and two in the Lodge. The service had started a significant programme of environmental work and did not intend to admit more than 12 patients for the foreseeable future. One patient was in long term segregation.

Cygnet Wast Hills is registered with the Care Quality Commission for the following regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder, or injury

Both the Main House and The Lodge are period properties, and the Annexe is a single-story building of more recent construction. The buildings, location and layout were not suited to modern day psychiatric care. The hospital is set in six acres of ground. The hospital admitted people from throughout the United Kingdom.

The service is commissioned through clinical commissioning groups. The hospital director was the registered manager and had been in position since August 2021.

We last inspected this service in May 2021. At that inspection we identified areas of concern, rated the service inadequate and placed the service under special measures.

We carried out this inspection due to concerns we identified at our previous inspection when we rated the service inadequate. At this inspection we looked at all the key lines of enquiry and checked whether the service had made improvements following concerns identified at our last inspection.

What people who use the service say

We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked that this was a suitable communication method and if people were happy to use it with us. In this report, we used this communication tool with one person to tell us their experience

We spoke to three people at the service and their feedback was positive They told us that staff were kind and caring and respected their privacy. We asked two people about activities, and they told us they took part in a range of activities including cooking meals for themselves. People told us they felt safe.

Summary of this inspection

Commissioners fed back that they did not have current concerns and that they felt improvements had been made at the service.

At this inspection advocacy said they still had some concerns about specific cases. However, in the main they thought improvements had been made since our last inspection.

There had been no formal complaints made about the hospital since our last inspection. However, there were some concerns from a parent that had been informally shared with us, we spoke to this parent as part of our inspection. We spoke to seven families. Feedback from these families was mixed.

Overall families thought there was enough nursing staff, and that activities and leave were not cancelled due to insufficient staffing. Families thought there was adequate access to a doctor and their family member was safe in the hospital environment. However, two families thought noise or aggression from other people at the service had upset their family member. One family member said that their family member's belongings had been damaged and their possessions had been lost.

Families told us most staff were kind and there were some very caring members of staff. They knew how to make a complaint but not all families said they were actively asked for feedback. However, they knew how to give feedback if they wanted to.

Five of seven families identified they were concerned about their family member's weight. Four families did not think their family member's weight was well managed, and they were concerned about weight loss or weight gain. There were concerns about their family member's having a healthy diet.

Not all families thought there was enough activity for people, this included work opportunities and life skills. Two out of four families said there were insufficient life skills and three out of five families said there was not enough to do.'

Not all families were satisfied with the way the hospital communicated with them and the way information was shared in the hospital. Not all parents felt involved in the care plan of their family member. Three out of five families told us that either they had not seen a care plan or did not feel involved in care plan. Four families provided feedback about communication from the hospital, two of these families gave negative feedback and two gave mixed feedback.

How we carried out this inspection

This was an unannounced comprehensive inspection.

We were on site for four days. Our inspection team comprised of a head of hospital inspection, two inspection managers, a pharmacy inspector, three inspectors, a Mental Health Act reviewer and specialist advisor. The team was on site for some or all four of these days. An expert by experience carried out telephone interviews with family members.

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During this inspection, the inspection team:

- spoke with three people in the service

Summary of this inspection

- spoke with 12 members of staff including the consultant psychiatrist, speech and language therapist, occupational therapist, psychologist, nurses, and support workers,
- interviewed two senior managers,
- looked at the quality of the hospital environment,
- looked at six patients' care and treatment records in detail and reviewed sections of five other patients' care and treatment records,
- spoke with seven family members,
- observed peoples' care,
- spoke to stakeholders including GP, commissioners, pharmacist, and advocate,
- looked at other documentation and records related to peoples' care and overall governance of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations.

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with the following legal requirements.

The provider must review all patients' physical health records to ensure:

1. Physical health monitoring is completed fully and recorded according to the provider's physical healthcare policy.
2. Patients' weights are recorded at admission, monitored throughout treatment and where necessary specific care plans are in place for patients who require weight management.
3. Hospital passports contain accurate and up to date information. **(Regulation 12 (1) (2) (a) (b))**

The provider must ensure that fire doors that should be closed are closed in the Annexe. (**Regulation 15 (1)(d))**

The provider must continue to develop an individualised activity programme, so all patients are meaningfully occupied including in the evening and at weekends. The service must review all patients' sleep routines and ensure staff always record activity offered and engaged with. **(Regulation 9 (1) (a) (b) (c))**

The provider must ensure that out of date oxygen is labelled as out of date and not stored in an area where staff may accidentally use it. Notices informing staff about the location of oxygen should be up to date. **(Regulation 12 (2) (e))**

The provider must ensure the hospital environment is both clean and safe for patients and ensure environmental risk assessments reflect current risks **(Regulation 15 (1) (d))**

The provider must ensure that the sensory room in the Annexe can be used by patients for its intended purposes. **(Regulation 15 (1) (d))**

The provider must ensure medicines are administered correctly in line with the prescription and with the correct legal authority under the Mental Health Act.**(Regulation 12 (1) (2) (g))**

Summary of this inspection

The provider must improve their governance systems, through effective auditing to ensure that care and treatment is effective and meets the needs of patients. This should include audits of:

1. Care records to ensure they are complete, accurate and information is easily locatable.
2. Physical health records to ensure that physical health assessments, observations and associated documents are complete.
3. Patient's activity levels to ensure that patients are involved with meaningful activity including activity that prepares them for discharge. **(Regulation 17 (1) (a) (b) (c)**

Action a provider SHOULD take is to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

The provider should meet with families to ask for their views and this should include their views on improving healthy lifestyles and healthy eating for patients. **(Regulation 9 (3) (f))**

The provider should continue to support staff in meaningfully engaging with patients when completing high level observations and treating patients with dignity. **(Regulation 10 (1))**

The provider should ensure all aspects of risk are clearly recorded in the risk register. **(Regulation 17 (1) (a))**

The provider should ensure staff record when they have completed psychological interventions with patients. **(Regulation 17 (1) (2) (c))**

The provider should ensure that it implements the guidance 'Right Support, Right Care, Right Culture' as part of its model of care. **(Regulation 17 (1) (a))**

Our findings

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	Inadequate	Requires Improvement	Good	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Requires Improvement	Good	Inadequate	Inadequate

Inadequate

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments

Not all wards were safe and clean and well maintained. Staff completed and regularly updated risk assessments of all ward areas, but these had not identified all environmental hazards and issues with cleanliness.

Safety of the ward layout

The provider had made environmental improvements in the Main house since our last inspection. However, we saw two environmental risks visible in peoples' areas of main house on which people could have hurt themselves. The provider resolved these risks immediately after we identified them.

The Annexe bathroom was not suitable for people to use. The panel was coming away from the bath and there was poor surface integrity; bathroom seals were mouldy around the bath and there was a mouldy bath toy in the bathroom.

At the time of our inspection there were refurbishments being made to the kitchen in the main house. This meant the kitchen was not in use at the time of our inspection. Staff used the occupational therapy kitchen in the four days during which the work was being completed.

Fire doors in the Annexe that should have been closed had been propped open by staff. This was against fire regulations.

The hospital did not have clear lines of site. There were narrow corridors and blind corners. However, all people were observed by one or more staff which meant that potential risks were reduced. The service also had convex mirrors and CCTV.

The ward complied with national guidance and there was no mixed sex accommodation.

Inadequate

Wards for people with learning disabilities or autism

The service had up to date ligature risk assessments. Staff knew about any potential ligature anchor points and mitigated the risks to keep people safe.

There were environmental risk assessments, but these had not identified all risks in the environment.

Staff had easy access to alarms and people had easy access to nurse call systems.

Maintenance, cleanliness, and infection control

The main house and Lodge ward areas were clean and cleaning records indicated cleaning had been completed.

The service had started their programme of environmental improvement in the main house and therefore the house was better maintained. However, the Annexe looked neglected and despite records having been completed, not all areas of the Annexe were clean. The kitchen was dirty, the oven was mouldy, and the fridge where people's food was stored was visibly very dirty. The Annexe bathroom was not clean and windows throughout the Annexe were dirty. When we identified this at inspection the provider did immediately clean the area and complete an investigation of why the kitchen was dirty. On the second day of our inspection the Annexe felt cold. It was relying on temporary heating as there was a fault found with the ordinary heating system. This was attended to by the provider and heating was reinstated the following morning.

Staff followed infection control policy, including handwashing, and wearing masks to reduce the spread of COVID-19. The provider kept a record of COVID-19 vaccinated staff and encouraged staff to be vaccinated.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible equipment and emergency drugs that staff checked regularly. Emergency equipment was kept in nursing stations in the Annexe and Lodge and in the reception area in the main house. However, we found out of date oxygen in clinic rooms. This could have been confusing for nurses who had access to the clinic room and they may have used out of date instead of in date oxygen in an emergency. In the Annexe there was information about where oxygen could be located, but this was not up to date and therefore could have been confusing for staff in an emergency.

Staff checked, maintained, and cleaned clinical equipment.

Safe staffing

The service had enough nursing and medical staff, who knew the people at the service and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep people safe. The service had increased staff numbers on shift since our last inspection and recruited more nurses. Staff told us there were enough staff on shift to provide planned peoples' care and there were extra support workers called 'floating staff' to ensure adequate cover and flexibility.

The service required 14 whole time equivalent nurses and had 11 in post with two more nurses recruited and due to commence work.

The service continued to have high levels of vacancies for support staff. There were 110 whole time equivalent support workers required for the service and 55 in post. Twelve support staff had been recruited and were due to start in position.

The service had a proactive recruitment programme. The service had introduced value-based recruitment open days so that they could attract staff with the right values to work in the service.

The service regularly used agency support workers. Agency staff use was 43% during the week of our inspection. Managers requested staff familiar with the service and told us 90% of agency staff worked regularly at the hospital, this meant they knew the people at the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had reducing turnover rates. There had been a significant reduction between 1 June and 30 November 2021. At the time of our inspection staff turnover was at 4% compared with 12% in June 2021.

Managers supported staff who needed time off for ill health, but levels of sickness were low and reducing. There had been a gradual reduction in sickness between the 1 June and 30 November 2021. At the time of our inspection the staff sickness rate was 1% compared with 6% in June 2021.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers could adjust staffing levels according to the needs of the people. There was a qualified nurse available in communal areas.

People had regular one-to-one sessions with their named nurse.

People rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep people safe. There were daily meetings and handovers between staff. Staff had access to 'grab files' which contained vital information about each person. High level observation records contained all relevant risk information.

Medical staff

The service had enough daytime and night-time medical cover. There was a speciality doctor and a consultant psychiatrist available for people. There was a doctor on call. Although they did not usually attend the site they could in a psychiatric emergency. In the case of a physical emergency staff called emergency services for support.

Mandatory training

Staff had completed and kept up to date with mandatory training. Staff compliance with training was 94%. There was no training area that fell below 85%, which was the provider's target.

Inadequate

Wards for people with learning disabilities or autism

The mandatory training programme was comprehensive and met the needs of people and staff

Managers monitored mandatory training and alerted staff when they needed to update their training. There was information at hand for them to identify any staff that had not completed their training.

Assessing and managing risk to people and staff

Staff assessed risk to people and themselves. They did not manage those risks in all areas including peoples' physical health, activities supporting discharge and the environment. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating, and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of peoples' risk

Staff completed risk assessments for each person on admission, using a recognised tool, and reviewed this regularly, including after any incident. We looked at eight risk assessments and these were all up to date and detailed with a risk management plan.

Management of peoples' risk

Staff identified and responded to any changes in risks to, or posed by, people. Staff completed risk assessments after incidents and reviewed them regularly; these were up to date.

We reviewed peoples' therapeutic observation records and observed staff practice to complete observations. Records were completed correctly and indicated staff completed and recorded peoples' observations safely. All staff had been trained in how to do this and had their competency assessed. However, we reviewed CCTV footage and saw that on one occasion staff had not followed the enhanced observation care plan as prescribed.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards and staff used de-escalation. Staff reviewed any restrictions to ensure they were not blanket restrictions regularly and considered people' individually.

Use of restrictive interventions

Levels of restrictive interventions had reduced since our last inspection. We saw that there had been an overall reduction in the use of restraint. We compared data from the five months prior to our last inspection with data from five months prior to this inspection. We saw that restrictive interventions had reduced by 15%. On average across the five months lower levels of restraint accounted for two thirds of total restraints. We compared data about rapid tranquilisation from May 2021 until November 2021 and saw that there was a reduction in its use.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained people only when these failed and when necessary to keep the person or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Inadequate

Wards for people with learning disabilities or autism

Staff followed the National Institute for Health and Care Excellence guidance when using rapid tranquilisation. This had improved since our previous inspection, staff now completed physical health checks following the administration of rapid tranquilisation.

The service did not use seclusion and there were no seclusion facilities.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, for monitoring a patient in long-term segregation.

Safeguarding

Staff understood how to protect people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training appropriate for their role on how to recognise and report abuse. Staff kept up to date with their safeguarding training and overall training compliance was 87%. Support workers completed Level 2 training, registered nurses Level 3 training and safeguarding leads completed Level 4 training.

Staff could give clear examples of how to protect peoples from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. There were examples of this having taken place.

Staff followed procedures to keep children and adults visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service raised safeguarding alerts and notified the Care Quality Commission when they did this.

Staff access to essential information

There were some gaps and inaccuracies in care records. In addition, it was not always easy to locate all information.

Peoples' notes were stored securely. However, there were gaps in recording particularly in relation to physical health. We also found that the names of people were not always correct and on four separate occasions we found incorrect names were recorded in clinical records.

We spoke to a family member who also told us that incorrect names had been used in her relative's care records. This indicated that record keeping was not always accurate and could cause confusion or be a breach of information governance.

It was not always easy to locate information as there were electronic and paper records stored in several files. This meant that sometimes information that should have been recorded in one place was recorded somewhere else and made it hard to locate.

Inadequate

Wards for people with learning disabilities or autism

Medicines management

Medicines were not always administered in line with prescriptions and the correct legal authority under the Mental Health Act was not always in place for prescribed medicines. The service used systems and processes to safely record and store medicines. Staff regularly reviewed the effects of medicines on each person's mental and physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism, or both).

Medicines had not been prescribed with the correct legal authority under the Mental Health Act on two occasions. On one of these occasions a Second Opinion Doctor had not been requested and on another the correct legal form had not been appointed.

Medicines were administered at the right time. However, administration of as required medicines to manage behaviour that challenged had exceeded the maximum prescribed dose for one patient on three separate occasions.

Staff reviewed each patient's medicines regularly and provided advice to people and carers about their medicines.

Staff completed medicines records accurately and kept them up to date. They stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted or discharged.

Staff learned from safety alerts and incidents to improve practice.

Overall, the service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. However, we also found one patient had been administered a dose of medicine to control behaviour in excess of their prescribed dose on three occasions.

The service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism, or both). We saw some patients had a reduction in prescribed anti psychotics. The STOMP audit demonstrated a clear reduction in prescribed medicines.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance.

Staff ensured that they monitored peoples' physical health after incidents of self-harm. For example, staff completed neurological observations after incidents of people head banging. This had improved since our last inspection.

Track record on safety

The service had improved their track record on safety following the previous inspection.

Reporting incidents and learning from when things go wrong

Inadequate

Wards for people with learning disabilities or autism

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

Staff knew what incidents to report and how to report them They raised concerns and reported incidents and near misses in line with policy, we saw there was an improvement in reporting incidents and staff were given feedback after incidents.

Staff reported incidents clearly and in line with policy. There had been no serious incidents since our last inspection. We reviewed incidents of self-harm, as this was an area of concern at our last inspection. In the five months prior to this inspection compared to the five months prior to our previous inspection moderate incidents of self-harm had reduced by more than half from 17 to seven.

Staff understood the duty of candour. They were open, transparent, and overall gave people and their families a full explanation when things went wrong. The service had omitted to notify a family of one incident but when they became aware of this omission, they immediately notified them.

Managers debriefed and supported staff and people after any serious incidents. The psychology team took a lead role in completing debriefs.

Managers investigated incidents thoroughly. People and their families received feedback from these investigations. Managers reviewed CCTV daily to check on the safety of the service. There was evidence that learning had come from these reviews. The hospital director told us that this played a key role in ensuring safety.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared learning from other services. Incidents were reviewed every day in morning meeting and all staff received a record of this meeting by email. The content of this meeting was discussed in staff handover.

Staff met to discuss the feedback and look at improvements of people's care. There were several well attended meetings that took place.

There was evidence that changes had been made because of feedback. For example, changes had been made following parental and external stakeholder feedback. The provider had developed an action plan following our previous inspection. External stakeholders had contributed to this and monitored progress and the provider had made improvements detailed in this report.

Managers were aware of the Learning from Deaths Mortality Review (LeDeR) Programme.

Are Wards for people with learning disabilities or autism effective?

Inadequate

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

Assessment of needs and planning of care

Inadequate

Wards for people with learning disabilities or autism

Staff undertook assessments when assessing the needs of people, but these did not always contain all the information required. Staff worked to develop individual care and support plans and updated them as needed. Most care plans reflected the assessed needs but were written in a prescriptive way.

Staff completed a comprehensive mental health assessment of each person either on admission or soon after.

People had their physical health assessed soon after admission although these were not always complete with records of patients' weights. Three of 12 patients did not have a baseline weight recorded when they were admitted to hospital. Without a base line weight, staff could not effectively assess and monitor whether patients were maintaining a healthy weight.

Staff developed care plans for each person that met most of their mental and physical health needs.

Staff regularly reviewed and updated care plans and positive behaviour support plans when person's needs changed. Positive behaviour support plans were present and supported by a comprehensive assessment. These were up to date, detailed and accessible for all staff.

Care plans were holistic and considered people's strengths, abilities, and preferences. However, they were written in a prescriptive way.

Best practice in treatment and care

Staff provided care and treatment for people in the service. However, the setting and design of the service did not fully reflect the CQC guidance 'Right support, Right Care, Right Culture' and work was required to ensure the service always delivered care in line with best practice and national guidance; The environment, care and treatment did not always meet peoples' needs. Adapted psychological therapies were not routinely offered and most people were not active enough or meaningfully occupied. Staff did not consistently support and monitor physical health or always encourage people to live healthier lives.

The provider had not considered the statutory guidance set by the CQC and therefore the model for the service did not fully reflect 'Right Support, Right Care, Right Culture.' For example, because of the structure of the building, the hospital was often noisy and whilst there was a sensory room in the house people in the Annexe did not have access to their sensory room as this was being used for storage. However, the provider told us after our inspection the patients in the Annexe did not wish to use the sensory room in their area. The environment did not meet peoples' sensory needs. The layout of the building caused people to meet each other. As a result, people could not always choose whether they wanted to use communal areas, and this did not always meet their preference or needs. People were not always meaningfully occupied. This meant people did not always have a good and meaningful everyday life. The hospital was located in secluded grounds not within the local community. This meant people did not have good access to the local community.

The psychology team supported people at the service and staff. They had an active role in the multidisciplinary team, playing a key role in analysis of incidents and risk assessment. They were able to provide examples of the work they had completed to support people. For example, in relation to sexual health and the development of sensory kits. However, at the time of the inspection the provider told us there there was only one person who was engaged in structured

adapted psychological interventions suitable for the patient group and staff had not recorded these in their care records. Following our inspection the provider has now told us that there were four people engaged in psychological therapy at the time of our inspection but the evidence we reviewed only gave an estimate of the level of psychological activity. This meant there were no formal clear records of the work carried out in patients' care records.

The hospital had appointed a new occupational therapist since our previous inspection. We saw improvements in relation to peoples' activity. There was a new activity timetable and further actions planned to develop activity. For example, two people had been on holiday and there were more group activities and work opportunities for people. However, at inspection people still were not engaged in enough activity, and we continued to see people inactive, sleeping excessively or demonstrating irregular sleep patterns.

The expected level of activity set by commissioners and the provider's model of care was 25 hours each week. We reviewed activity records for all 12 people at the service for the week commencing 7th November 2021 and saw that only one person completed 25 hours of activity. However, after our inspection the provider gave us further evidence which demonstrated that people were engaged with enough activity. During our inspection we observed people sleeping, inactive and not regularly engaged in activities. We were not assured people were meaningfully occupied seven days a week and that there was enough for them to do to help to prepare them for discharge. We did not consider all recorded activities to be meaningful.

Several people slept regularly in the day or had poor sleep patterns. We reviewed sleep charts for five people during October 2021. In four of these sleep charts, on average, people were found to be recorded as asleep in the afternoon or evening 22% of the time. This impacted on their quality of life and their ability to learn new skills to support a move back into the community.

Staff understood peoples' positive behavioural support plans and provided the identified care and support. All staff had access to these, and they were up to date.

Staff identified peoples' physical health needs and recorded them in their care plans. However not all physical health needs or observations were monitored, recorded, or updated.

Staff did not consistently monitor and record patients' weights. We looked at four patients' records for weights and saw patients were not always weighed monthly, and Body Mass Index was not always recorded. Some of these patients were overweight or on the borderline for being underweight.

Patients' physical health observations were not recorded properly, this meant staff did not have an accurate record of patients' physical health risks. NEWS2 (National Early Warning Score) were not complete for five patients and were not completed at least once a month in four sets of records. The National Early Warning Score (NEWS2) is a system for scoring the physiological measurements of patients to identify deterioration in physical early.

Physical health records were not always up to date. There were two hospital passports that had out of date information. When a person with a learning disability is admitted into hospital the hospital passport details all their essential information. Both contained out of date information for as required medicines and one of these was not up to date about a penicillin allergy. The lack of information about this allergy could have had significant consequences.

Staff made sure patients had access to physical health care, including specialists as required. There was a local GP who attended the hospital at least once a month. All patients had now received their annual physical health review, which had been overdue because of the COVID-19 pandemic.

All patients had received flu vaccinations, their first two COVID-19 vaccinations and some patients had now received their COVID-19 boosters.

There had been delays in patients accessing dental care due to the COVID-19 pandemic. As a result, the hospital had paid for a private dental service to ensure patients had their dental needs met. All people had been offered a dental appointment, some people had refused these and therefore these appointments had been rebooked. Staff had completed annual health reviewed for all patients.

Staff had recorded in patients' care records that they had access to chiropody and opticians review and electrocardiograms had been carried out.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. There were healthy meals and snack choices available. However, some people did consume a lot of sugary products, staff told us this was peoples' choice. Staff competed training in dysphagia. The speech and language therapist took a clinical lead in relation to eating and safety for patients who had difficulties swallowing. Staff made sure that peoples' food was suitable and safe for them. They made records of fluids and food consumed by people to make sure they ate and drank enough.

The hospital had introduced exercise and healthy eating groups for people and there was evidence of work being completed with people in relation to this. However, families had concerns about healthy eating, and we observed that people were inactive, and they did not always eat healthy food.

Staff used recognised rating scales to assess and record severity and outcome and completed audits. However, despite there being an improvement and activity plan in place, there were outstanding areas that required improvement.

Staff used suitable recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, the hospital used the Learning Disability Model of Human Occupancy Screening Tool (LDMOHOST), the Disability Distress Assessment Tool (DISDAT) and the Glasgow Depression Scale.

Staff used technology to support people to keep in contact with their families when they were unable to see them face to face.

Staff took part in clinical audits and there was a programme of improvement taking place. There were several clinical audits and managers used results from audits to make improvements and shared learning with the staff team. However, there were still areas that required improvement where audits completed or ineffective. For example, physical health monitoring, weight management, medicines and the Mental Health Act and record keeping.

Skilled staff to deliver care

The ward team included a full range of specialists required to meet the needs of people. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. Despite this, managers did not oversee the implementation of these skills to support people in their care pathway, including how to engage with people, to deliver activities and monitoring of physical health.

Inadequate

Wards for people with learning disabilities or autism

The service had access to a full range of specialists to meet the needs of people. This included a full-time psychiatrist, a speech and language therapist, psychologist and psychology assistant. Managers had identified areas they wanted to improve following our previous inspection and had recruited to a new role of deputy hospital director. There had been a new occupational therapist recruited and another occupational therapist was being recruited. The service had also increased the number of activity workers from one to three in role. There was a new role of a family liaison worker role to help to improve communication with, and provide a direct contact for families

Managers ensured staff had the right skills, qualifications, and experience to meet the needs of the people in their care, including bank and agency staff. Specialist training included areas specific to peoples' needs. For example, training in autism, dysphagia, accessible communication, and epilepsy.

Managers gave each new member of staff a full induction to the service before they started work. They ensured that staff completed shadowing shifts and had time to read about the people before they started working.

Managers supported staff through regular, constructive appraisals of their work. Staff appraisal compliance was at 97%.

Managers supported staff through regular, constructive managerial and clinical supervision of their work. Staff supervision compliance was at 86%. We reviewed eight supervision records which showed discussions took place about how staff demonstrated Cygnet values in their work.

The psychologist supported staff with group and individual reflective practice. All staff in the multidisciplinary team received profession specific supervision.

Managers made sure staff attended regular team meetings or shared information from those they could not attend. There was more than one opportunity for staff to attend the monthly team meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. There had been a focus on improving staff training compliance since our last inspection. For example, all staff had completed observation training and training around physical health. Managers made sure staff received any specialist training for their role ad completed competency assessments.

Managers recognised and managed poor staff performance. There were examples where poor performance was dealt with promptly and effectively.

Managers recruited, trained, and supported a person who had been discharged from the service to support people as an expert by experience and attend clinical governance meetings.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit people and supported each other. The team had effective working relationships with staff from services that would provide aftercare following the peoples' discharge. They engaged with them early after admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss people and improve their care. There were monthly ward round meetings for people and daily multidisciplinary meetings where people's progress, risk, and care and treatment was discussed. These meetings were attended by all staff disciplines including support workers.

Inadequate

Wards for people with learning disabilities or autism

Staff made sure they shared clear information about people and any changes in their care, including during handover meetings.

The staff team had effective working relationships with other teams in and external to the organisation.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. However, these were not always discharged as they should have been.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. There was a Mental Health Act administrator available to support staff.

The service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Patient's rights were made available in an accessible format for them.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff had omitted to request a second opinion from a Second Opinion Appointed Doctor (SOAD) on one occasion for a patient who required a SOAD. We asked the provider to do this at inspection, but the provider did not ensure this took place until we had requested for a second time that this be done.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers completed audits of the Mental Health Act and discussed the findings.

Good practice in applying the Mental Capacity Act

Inadequate

Wards for people with learning disabilities or autism

Staff supported patients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff could ask the multidisciplinary team about advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture, and history. Staff involved families and we saw assessments had been completed and the service worked with family and best interests' assessors to support patients.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Are Wards for people with learning disabilities or autism caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion, and support

Overall staff treated people with compassion and kindness and usually respected their privacy and dignity. They understood the individual peoples' needs and supported them to understand and manage their care, treatment, or condition.

Staff gave people help, emotional support and advice when they needed it. We observed that overall staff were discreet, respectful, and responsive when caring for people. However, we also observed that sometimes there continued to be limited staff interaction with the people they cared for. We saw that staff did not always engage people in activities but sat and observed them. On one occasion we saw a member of staff shout that a person was walking down the corridor to alert other staff to their movement. This was not a dignified way to talk about someone.

Inadequate

Wards for people with learning disabilities or autism

Staff supported people to understand and manage their own care treatment or condition. Social stories and talking mats were used to help people to understand their treatment in an accessible way that met their communication needs

Staff directed people to other services and supported them to access those services if they needed help. There were many examples of people accessing community health and leisure services.

People said staff treated them well and behaved kindly. We spoke to three people who said that staff were kind to them. Families told us most staff were kind.

Staff understood and respected the individual needs of each person, they could describe peoples' likes and dislikes, diet, risks, and interests. Staff we spoke to understood the care required for people's individual needs.

Staff felt they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards people. They said there was an open culture and managers actively encouraged them to share any concerns with them. Staff knew how to whistle blow.

Staff followed policy to keep peoples' information confidential.

Involvement in care

Staff involved people in care planning and risk assessment where people had capacity and sought their feedback on the quality of care provided. **They ensured that people had easy access to an independent advocate.**

Involvement of people

Staff introduced people to the ward and the services as part of their admission. The information that people were given was suitable for their communication needs.

Staff involved people who were able and supported them to engage in their care planning and discharge. Staff assessed peoples' capacity to identify if they were able to engage in their care plans.

Staff made sure people understood their care and treatment and found ways to communicate with people had communication difficulties. Staff were well supported and trained in communication by the speech and language therapist so they could effectively communicate in a way that suited the people. For example, staff used communication methods including Talking Mats, Picture Exchange Communication System, Makaton and signing that was specific to individual peoples' needs. All people had a communication care plan.

Staff involved people in decisions about the service. For example, people were asked to give feedback and help to plan menus and try out new meals. A person who had been discharged from the hospital in the role of an expert by experience now attended the hospital and clinical governance meetings and gave feedback to the service

People could give feedback on the service and their treatment and staff supported them to do this. There were regular community meetings, Peoples' Council meeting and available feedback forms that staff supported people to complete.

Staff supported people to make decisions on their care where possible.

Inadequate

Wards for people with learning disabilities or autism

Staff made sure people could access advocacy services and the advocate was regularly on site and contactable. We saw that people had advocacy involved with their care.

Involvement of families and carers

Staff told us they informed and involved families and carers appropriately. However, not all families and carers felt well supported.

Staff told us they supported, informed, and involved families or carers. There had been recent events for carers and staff gave family regular feedback. Most families said they received support when they required this. However, some carers did not think communication was as good as it could be. The hospital had introduced the family liaison worker to support improved communication and provided us with examples and evidence of communication with families.

Staff helped families to give feedback on the service. There was a survey taking place after our inspection, but the responses were due to be received after the inspection period. Managers shared with us compliments and concerns that had come from families and examples of where they had met with family members. Families told us they gave feedback.

Are Wards for people with learning disabilities or autism responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. However, peoples' discharge was often delayed due to availability of placements for people to move on to.

Bed management

The service admitted people from across the United Kingdom. This meant people were not located close to their families or their own communities.

Discharges were often delayed due to available placements, this meant people were often away from their families for longer than planned. This was not due to the provider and was because community placements or alternative suitable placements were often unavailable.

Managers regularly reviewed length of stay for people to ensure they did not stay longer than they needed to.

Managers and staff worked to make sure they did not discharge people before they were ready.

Staff did not move or discharge people at night or early in the morning. Discharges were planned for in advance and coordinated.

Inadequate

Wards for people with learning disabilities or autism

Discharge and transfers of care

Discharges were often delayed due to available placements, this meant people were often away from their families for longer than planned. This was not due to the provider and was because community placements or alternative suitable placements were often unavailable.

Managers regularly reviewed length of stay for people to ensure they did not stay longer than they needed to.

The hospital adopted the Cygnet model of care for the people with learning disability and autism spectrum disorder. This was a values-based model. The multidisciplinary care team had developed a care pathway for people who were involved in their discharge plans.

Staff carefully planned peoples' discharge and worked with care managers and coordinators to make sure this went well. The service worked with the advocate to support them to identify solicitors to work with people to achieve discharge.

At the time of our inspection there were seven people whose discharge was delayed and two of these people were discharged shortly after our inspection to live closer to their families.

Staff supported people when they were referred or transferred between services. The service worked closely with care managers to ensure transfers of care were completed in a way that was supportive of people's individual needs.

Facilities that promote comfort, dignity, and privacy

Each person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and people had access to hot drinks and snacks at any time.

Each person had their own bedroom, which they could personalise. Bedrooms were personalised and had a secure place to store personal possessions. However, we did see people asleep in their lounge areas.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where people could meet with visitors in private. However, one family said that they had not been able to use this room and another family said that it was small and not an ideal meeting place.

People could make phone calls in private.

The service had an outside space that people could access easily. The hospital had large well-maintained grounds with items for people to use outside. For example, a trampoline, swing, and football goals.

Staff supported people to access hot drinks and snacks.

The service offered a variety of good quality food.

Peoples' engagement with the wider community

Inadequate

Wards for people with learning disabilities or autism

Staff supported people with activities outside the service with family relationships. There were some work opportunities that had been recently introduced for people. People were not currently engaged in education, although the service had plans to develop this.

The service had recently introduced the opportunity for people to engage in paid work supported staff to complete practical tasks. The provider explained that they wanted work opportunities to be developed further for people that met their individual needs and ability. They were preparing to work with an accreditation body so that they could offer education and training opportunities for people that were meaningful for them.

Staff helped people to stay in contact with families and carers. Families and carers visited the service and used technology to have virtual meetings with family.

Staff encouraged people to develop and maintain relationships both in the service and the wider community. Friends and families could visit when they wanted to. Recently introduced group activities meant people had the opportunity to spend time together if they chose to.

Meeting the needs of all people who use the service

The service met the needs of all people – including those with a protected characteristic. Staff helped people with communication, advocacy, and cultural and spiritual support.

The service supported and made adjustments for disabled people and those with communication needs or other specific needs. In line with the Government Accessible Communication Standards, the provider ensured it met peoples' communication needs through a range of communication methods and styles that suited individual people. All people had a communication care plan specific to their needs. The speech and language therapist supported aspects of peoples' care with individually developed social stories so that people could prepare and understand their care and treatment.

Staff could access information leaflets available in languages spoken by people and the local community when required. Managers made sure staff and people could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual people. People had access to spiritual, religious, and cultural support if they required this.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Overall people at the service, relatives and carers knew how to complain or raise concerns and gave examples of when they had done so.

The service displayed information about how to raise a concern.

Staff understood the policy on complaints and knew how to handle them.

Inadequate

Wards for people with learning disabilities or autism

Managers had investigated complaints and identified themes, but there had been no formal complaints since our last inspection in May 2021. However, managers were open about informal concerns and gave examples of how they had responded to these.

Staff knew how to protect people who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and gave people and families feedback after the investigation into their complaint.

Managers shared feedback from informal complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care, these were shared with the staff team.

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

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Since the previous inspection, a new hospital director had been appointed. The leadership team at the hospital had delivered against most actions identified from the previous inspection, but the improvements they made had not been fully embedded. There were concerns we raised at this inspection that the leadership were not aware of. This had an impact on people at the service. We were not assured that the care pathway for people was being delivered as it should within the model of care. Leaders had improved their visibility and were approachable for people, families and staff.

Leaders had the skills and experience to perform their roles. There was a recently appointed hospital director, deputy director and clinical leader since our previous inspection. The role of deputy director was a completely new one. Although leaders had knowledge of managing a hospital for people with a learning disability, we were not assured that the guidance in the CQC guidance Right Support, Right Care, Right Culture was understood and embedded. This was not part of the model of care for the provider and the hospital. Leaders understood the service they managed. They could explain how the teams were working to provide care. However, there were concerns we found that leaders were not aware of at this inspection that led to further regulatory breaches. Leaders continued to work on the action plan from the previous inspection, but these changes required further embedding and needed to be sustained.

Leaders were visible in the service and approachable for people and staff. All staff and all stakeholders without exception described approachable and visible leadership. All stakeholders were complimentary about leaders.

Leadership development opportunities were available, including opportunities for staff below team manager level. There were opportunities and training for staff who wished to take lead roles.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. The organisational vision and values were visible in the service and embedded in staff appraisals.

The most senior leaders had visited and supported the hospital since our last inspection.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff told us they were listened to and engaged in service improvement.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff felt respected, supported, and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt respected, supported, and valued they were positive about the team they worked in.

Staff felt positive and proud about working for the provider and their team and described the improvements that had been made.

Staff felt able to raise concerns without fear of retribution. Staff were clear that there was an open culture and that they were actively encouraged to speak out and share concerns.

Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian. The Guardian had visited the service and there was information about them accessible to staff who worked at the hospital.

Managers dealt with poor staff performance when needed, managers provided us of examples of where disciplinary processes had been followed where there were concerns about staff members.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

Staff appraisals included conversations about career development and how it could be supported.

Staff reported the provider promoted equality and diversity in its day-to-day work and provided opportunities for career progression. There had been a recent staff welfare survey which included questions about equality and diversity. Overall, the survey indicated that most staff were happy with the provider, their team and leaders and felt there was equality in the workplace for all staff.

The service's staff sickness and absence rate met the provider's target and sickness and absence had reduced in the five months prior to our inspection.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

The provider recognised staff success within the service through staff awards.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively in all areas. The service had made improvements following our previous inspection, but they still needed to be embedded. However, there were still areas where performance needed to be improved.

There was insufficient governance oversight in the following areas.

There was a lack of oversight of the hospital environment. It contained risks that the provider had not identified until we raised concerns. The Annexe was not clean or suitable in all areas for peoples' care and treatment. This put people at risk of harm.

Physical health monitoring was not always completed and recorded according to the provider's physical healthcare policy. Peoples' health care information was not always up to date. Peoples' weights were not consistently recorded at admission and monitored and managed throughout treatment.

Medicines were not always administered correctly, in line with the prescription and with the correct legal authority under the Mental Health Act. This put people at risk of harm and meant that people's rights under the Mental health Act were not followed.

People were not always supported to have a good and meaningful everyday life. Whilst there had been an increase in activities offered since our last inspection, there was further improvement required, we saw inactive and sleeping people at this inspection as we had at our last inspection.

The provider had not ensured that the service delivered reflected the guidance Right Support, Right Care, Right Culture. The hospital had plans for significant environmental changes so that they could better meet the needs of people, however planning permission had yet to be sought for a significant part of this work.

There was, however, a clear framework of what must be discussed at ward, team, or directorate level in team meetings to ensure essential information, such as learning from incidents and complaints, was shared, and discussed. Information was shared across local and regional governance meetings and team meetings.

Staff had implemented recommendations from incidents and safeguarding alerts. Learning from incidents was investigated and regularly shared.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the people. The provider worked closely and effectively with commissioners and other community services to support service users.

Management of risk, issues and performance

Inadequate

Wards for people with learning disabilities or autism

Teams had access to most of the information they needed to provide safe and effective care but there was information missing from the risk register.

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required. However, the risk register did not include the changes required to the hospital environment or detail any current risks. This put people at risk of harm.

The service had plans for emergencies. For example, adverse weather or a flu outbreak. These were accessible to staff.

There were no current cost improvements taking place.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in improvement activities. However, there were still areas that required improvement.

The service used data systems to collect data that were not over-burdensome for frontline staff. The systems to embed data and use it to improve the service were in their infancy and were not embedded into the work on the wards to improve patient care.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well, and helped to improve the quality of care.

Information governance systems included confidentiality of peoples' records.

Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and people's care.

There had been a significant action plan in place since our last inspection and this identified actions with clear time frames. However, there were new issues identified at this inspection that the provider's information systems and processes had not identified. There were examples where audits had not helped staff to identify the issues.

Staff made notifications to external bodies as needed. We checked this and the provider notified the Local Authority safeguarding team, the CQC and Clinical Commissioners of incidents.

Engagement

Managers engaged actively other local health and social care providers to ensure actions that required change since the precious inspection were met. Managers from the service participated actively in the work of the local transforming care partnership.

Staff, people, and carers had access to up-to-date information about the work of the provider and the services they used. The hospital had introduced a newsletter to share what was happening with families. A family member now attended monthly clinical governance meetings for the service.

People and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The responses were due to be returned after our inspection.

Managers and staff had access to the feedback from people, carers and staff and used it to make improvements. The family liaison worker was on site at the weekend to ensure there was someone available for family to speak to.

People were involved in decision-making about changes to the service, community meeting records demonstrated this. Most carers felt they were asked for feedback about the service

People and staff could meet with members of the provider's senior leadership team to give feedback. Senior leaders had been on site at Wast Hills and were contactable if required.

Managers engaged with external stakeholders such as commissioners on a regular basis and provided information and updates in respect of people's progress and the hospital's improvement programme.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and this led to changes. The service had an action plan which staff had contributed to and which external stakeholders such as placing commissioners, were satisfied with. In addition, staff had implemented changes. For example, the introduction of sensory integration work by the occupational therapist, exchanges in training and learning between the consultant psychiatrist and the external pharmacy support and the introduction of the family liaison worker to better meet the needs of family. Staff were involved in the current programme of improvement and staff told us they were listened to when they made suggestions or put forward ideas.

The provider had recently teamed up with a company that specialised in anti-bite clothing with a view to seeing if it helped to reduce incidents and improve care.

The psychology team were involved in developing a Compassion Focussed Therapy (CFT) Manual in an easy-read format for people with learning disabilities. The plan was to use this at Wast Hills and across the wider organisation.

Cygnet had started training staff in Quality Improvement across the organisation, 44% of staff at the hospital had completed this training. The service was not yet using formal quality improvement methods at the time of our inspection but was engaged in a programme of improvement.

Staff had recently participated in an organisation-wide audit to review peoples' activities.

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 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not developed a full, individualised activity programme, so that all patients were meaningfully occupied including in the evening and at weekends. The service had not reviewed all patients' sleep routines and ensured staff always recorded activity offered and engaged with.

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 Physical health monitoring was not always completed fully and recorded according to the provider's physical healthcare policy. Patients' weights were not always recorded at admission, monitored throughout treatment and where necessary specific care plans were not always in place for patients who required weight management. Hospital passports did not always contain accurate and up to date information The provider did not ensure that out of date oxygen was labelled as out of date and it was stored in an area where staff may have accidentally used it. A notice informing staff about the location of oxygen was not up to date. The provider did not always ensure medicines were administered correctly in line with the prescription and with the correct legal authority under the Mental Health Act.

This section is primarily information for the provider

Requirement notices

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 Governance audit systems did not ensure that care and treatment was always effective and met the needs of patients in the following areas: Care records were not always complete and accurate and information was not easily locatable. Physical health records did not always contain physical health assessments, observations and associated documents. Not all patients were involved with meaningful activity including activity that prepared them for discharge.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had not ensured that fire doors that should have been closed were closed in the Annexe. The provider had not ensured the hospital environment was both clean and safe for patients and that environmental risk assessments reflected current risks. The provider had not ensured that the sensory room in the Annexe could be used by patients for its intended purposes.