Cygnet Appletree

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

We have taken enforcement action against the registered provider in relation to our concerns about this location. However, we did not re-rate Cygnet Appletree following this focused inspection. This is because the service type had changed since our previous inspection in August 2019.

We found the following issues that the provider needs to improve:

- The service did not have effective systems in place to ensure patient safety on the ward. There was no comprehensive environmental risk assessment in place to identify all ligature risks and blind spots on the ward, and staff did not have a full understanding of how to mitigate such risks. Staff did not follow the hospital processes and policies in recording patient risk, resulting in patients being exposed to harm.
- The service did not have robust systems in place to ensure that staff were adhering to safe practice. Ongoing physical health monitoring was not consistent for all patients or in line with Cygnet processes. Monitoring of patients following the use of rapid tranquilisation was not in line with The National Institute for Health and Care Excellence guidance. All

Summary of findings

clinical staff had not completed training in intermediate life support as recommended by The Resuscitation Council (UK) and staff were not following the guiding principles of the Mental Health Act Code of Practice in relation to the seclusion and segregation of patients.

- Staff did not follow Public Health England guidance in the use of personal protective equipment related to COVID-19. Nor did the service have their own systems for ensuring COVID-19 safety that were equal to, or better than the guidance from Public Health England.
- Staff did not have adequate training to ensure that all incidents were reported accurately and in full. Incidents were not investigated by management and there were no systems in place to identify learning from incidents or share learning with staff.
- Staff had not received supervision and appraisal in line with Cygnet policy.
- Managers failed to provide assurance that they had oversight of the service they managed. They did not thoroughly investigate all concerns raised with them. Staff reported feeling disrespected by other members of the team. The service did not follow company policy in relation to family members working together and being line managed by one another.

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		See detailed findings below.

Summary of findings

Contents

Cygnet Appletree

Services we looked at:

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

Summary of this inspection

Background to Cygnet Appletree

Cygnet Appletree provides acute and psychiatric intensive care services for patients who are detained under the Mental Health Act 1983 or admitted as informal patients. The hospital admits female patients aged 18 and over. The hospital changed from a high dependency rehabilitation unit to an acute and psychiatric care service in April 2020. It is situated in its own grounds in Meadowfield, close to the city of Durham.

The hospital is split over two wards; Bramley ward and Pippin ward. Bramley ward is a 16-bed acute ward providing care and treatment for people who are acutely unwell and whose mental health problems cannot be treated and supported safely or effectively at home. Bramley ward had not opened at the time of our inspection, so we did not visit this ward. Pippin ward is a 10-bed ward providing high intensity care and treatment for people whose illness means they cannot be safely or easily managed on an acute ward. Patients normally stay in a psychiatric intensive care ward for a short period before they can transfer to an acute ward once their risk has reduced.

At the time of inspection, the hospital had nine patients. The hospital had a registered manager and a controlled drugs accountable officer. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations. Controlled drugs accountable officers are responsible for all aspects of controlled drugs management within their organisation.

Cygnet Appletree has been registered with the CQC since 26 September 2012. Cygnet Appletree has previously been managed by two other providers. In March 2018, the provider of Appletree became Cygnet Behavioural Health Limited and the hospital was re-named Cygnet Appletree.

It is registered to carry out two regulated activities; assessment or medical treatment for persons detained under the Mental Health Act 1983, and treatment of disease, disorder, or injury.

Cygnet Appletree has previously been inspected seven times. The most recent prior to this inspection was a comprehensive inspection that took place on 7 August 2019. At that time Cygnet Appletree was a high dependency rehabilitation unit. The service was rated good overall with one 'should do' action identified.

The findings in this inspection report relate to Pippin ward only. Bramley ward was not open at the time of our inspection.

Our inspection team

The team that inspected the service comprised of three CQC inspectors.

Why we carried out this inspection

We inspected this service in response to whistleblowing concerns that we received. The concerns highlighted issues in patient safety, culture and incident monitoring.

Summary of this inspection

How we carried out this inspection

This was an unannounced inspection where we focused on specific key lines of enquiry in the safe, effective, caring and well led domains. We inspected the service over two days including visiting the service out of hours, in the evening.

Before the inspection took place, we reviewed a range of information provided by Cygnet, including:

- Staffing rotas.
- Pippin ward ligature risk assessment.
- Incident data.
- Policies and procedures.
- One patient's risk management plan and physical care plan.

We conducted a remote Mental Health Act monitoring visit the week prior to our inspection, which involved speaking to five patients and three carers/family members of the patients at Cygnet Appletree.

We also contacted the placing authorities for the patients that were admitted to Cygnet Appletree to gather their feedback on the service.

During the inspection visit, the inspection team:

- Spoke with the service manager
- Spoke with the registered manager
- Spoke with four other staff members; including nurses and health care assistants
- Spoke with five patients
- Observed staff interactions with patients

Reviewed three care records

What people who use the service say

The patients we spoke to provided mixed feedback about the service and staff members.

We received both positive and negative feedback regarding the staff at the service and the way they treated patients.

Patients told us the food was nice and there was a good selection of meals available.

Patients also told us they enjoyed the activities and mindfulness sessions through the week, however there was not a lot to do on the weekend.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We have taken enforcement action against the registered provider in relation to our concerns about this location. However, we did not re-rate Cygnet Appletree following this focused inspection. This is because the service type had changed since our previous inspection in August 2019.

We found the following issues that the provider needs to improve:

- The ward did not have comprehensive environmental risk assessments in place.
- Staff were unaware of ligature points and blind spots on the ward or how to mitigate these.
- Staff were not following their own policy and the most up to date Public Health England guidance in the use of personal protective equipment.
- Staff had not carried out individual risk assessments with patients on the use of personal protective equipment and COVID-19
- Staff were not following the providers processes in documenting patient risk to ensure patient safety on the ward.
- Not all clinical staff were trained in immediate life support as recommended by The Resuscitation Council (UK).
- Staff were not fully trained in the use of their incident recording system which meant incidents were not recorded comprehensively.
- Physical health monitoring following the use of rapid tranquilisation was not being carried out in line with the most up to date guidance.
- Staff had not identified incidents of safeguarding on five occasions where a patient was exposed to risk of harm.
- Staff were not following the guiding principles of the Mental Health Act Code of Practice and, where necessary, applying the Code's safeguards in relation to seclusion and segregation.

Are services effective?

We have taken enforcement action against the registered provider in relation to our concerns about this location. However, we did not re-rate Cygnet Appletree following this focused inspection. This is because the service type had changed since our previous inspection in August 2019.

We found the following issues that the provider needs to improve:

Summary of this inspection

- It did not meet legal requirements relating to Regulation 18 HSCA (RA) Regulations 2014. Staff were not being supervised and appraised in line with the providers supervision policy.
- Staff were not always carrying out ongoing physical health monitoring of patients, resulting in a patient being exposed to harm.
- All care plans relating to COVID-19 were identical for each patient.
- Staff did not complete any specific training or have access to guidance or support when the ward changed from a rehabilitation unit to a psychiatric intensive care unit.

Are services caring?

We have taken enforcement action against the registered provider in relation to our concerns about this location. However, we did not re-rate Cygnet Appletree following this focused inspection. This is because the service type had changed since our previous inspection in August 2019.

We found the following issues that the provider needs to improve:

- We received mixed feedback from patients on the ward. During the inspection five patients gave us positive feedback about the care and treatment they received. However, negative feedback was received from four patients during our Mental Health Act monitoring visit, including one patient saying they felt belittled by staff.
- Weekly community meetings which allow patients to feedback about the service had stopped taking place.
- The staff did not pro-actively involve family and carers in the patients care.
- The service did not have a process in place to allow family and carers to give regular feedback about the service.

We also found the following areas of good practice:

- We witnessed positive interactions between staff and patients.

Are services responsive?

We did not rate the responsive key question at this focused inspection as we did not inspect this domain.

Are services well-led?

We have taken enforcement action against the registered provider in relation to our concerns about this location. However, we did not re-rate Cygnet Appletree following this focused inspection. This is because the service type had changed since our previous inspection in August 2019.

Summary of this inspection

We found the following issues that the provider needs to improve:

- Leaders failed to provide assurance that they had a good understanding and oversight of the service they managed.
- Staff told us they felt disrespected, treated differently to others and had experienced allegations regarding bullying on the ward.
- Managers did not thoroughly investigate and take concerns raised with them seriously.
- Managers were not following the providers policy with regards to members of the same family working together.
- Managers did not have processes in place to review, investigate and learn from incidents on the ward.

Detailed findings from this inspection

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	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

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

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Safe and clean environment

The ward had an environmental risk assessment in place that did not specifically identify all ligature points in each room. A ligature point is anything which can be used to attach a cord, rope or other material for the purpose of hanging or strangulation. There were ligature points located in all areas of the ward. The environmental risk assessment stated that risks will be mitigated by "Staff awareness, correct level of observation following individual daily risk assessment". We spoke to four staff including a nurse and support workers and two members of staff were unable to identify more than two ligature points and the remaining two members of staff could not identify any.

The ward layout did not allow staff to observe all parts of the ward. The environmental risk assessment did not identify any blind spots on the ward, including how they would be mitigated. Staff told us that a risk assessment for blind spots had not taken place since the ward changed from a rehabilitation unit to a psychiatric intensive care unit.

Patients were risk assessed and management plans put in place in order to mitigate risks. Staff told us they would identify patients' current risk through handover meetings. However, full risk management plans for each patient were read out in handover meetings, which meant staff had to remember the information for multiple patients to ensure their safety on the ward. Staff told us that it is a lot of information to remember, especially for agency staff and new members of staff.

Staff had easy access to alarms and patients had easy access to nurse call systems. All the staff we spoke to told us they felt safe on the ward.

We were not assured that the care was COVID-19 safe, meaning staff and patients were exposed to the risk of harm. Staff were not following the most up to date guidance on the use of personal protective equipment. When we arrived on-site the staff we initially came into contact with were not wearing any personal protective equipment. When staff were asked to explain the reason for personal protective equipment not being used, they were unable to give a clear explanation. We saw that staff were not wearing gloves during physical contact with patients. This was not in line with the most up to date Public Health England guidance on the use of personal protective equipment. We saw that managers were continually removing their masks during our visit and putting them back on when members of our inspection team entered the room. We saw that patients were not wearing masks at any point during our visit, and there was no evidence of personalised risk assessments relating to COVID-19 and personal protective equipment being completed with patients. This was not in-line with Cygnet policy on the use of personal protective equipment and COVID-19.

Safe staffing

The compliance for mandatory and statutory training courses on 6 August 2020 was 90%. Immediate life support training was low with 50% compliance. The Resuscitation Council (UK) recommends that all clinically trained staff (doctors and registered nurses) who deliver or are involved in restraint or rapid tranquilisation should receive training in immediate life support as a minimum standard. Following the inspection, the provider told us that a further three members of staff had completed the training bringing the compliance up to 80% and that the remaining two members of staff had training dates booked.

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

During the inspection we reviewed three care records. Staff used the Short-Term Assessment of Risk and Treatability tool, which is a recognised risk assessment tool to support clinical risk management. We found that staff had completed a risk assessment of every patient on admission and updated it regularly, including after any incidents. However, staff were not always aware of specific patient risks. The ward had observation sheets in place for each patient which provided an overview the patients' risk, what level of observation the patient was on and the reason for their level of observation. We reviewed the observation sheets for five different patients from 1 August 2020 to 5 August 2020, none of these had been completed comprehensively. Each had important information about patient care and level of risk missing from the written records. In the three months prior to inspection we identified five incidents where a patient had been harmed or exposed to the risk of harm whilst on one to one observation.

None of the patients' care plans we reviewed had risk assessments in place for the use of personal protective equipment.

Prior to our inspection we requested incident data for the period between 27 April 2020 to 21 July 2020. Due to the incident data not being recorded comprehensively we were unable to identify if de-escalation techniques were used regularly prior to patients being restrained. Of the 236 incidents reported in that timeframe, 114 incidents did not state if restrictive interventions had been used or not. From the data, we also identified one episode of an unauthorised technique being used to restrain a patient. The ward manager was unaware of the incident and could not provide any evidence of follow up action being taken to prevent it happening again.

From the incident data there were 114 incidents which did not state if rapid tranquilisation had been used or not. When rapid tranquilisation was used staff did not follow The National Institute for Health and Care Excellence guidance. The guidance states that staff should monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. Out of 236 incidents recorded between 27 April 2020 to 21 July 2020, there were 29 incidents which stated rapid tranquilisation was used. Patients were monitored for less than an hour on nine occasions. With one record stating that a patient was monitored for only one-minute following the use of rapid tranquilisation.

During our visit we asked to review the paperwork for the monitoring of rapid tranquilisation throughout July. Rapid tranquilisation was used twice. Staff were only able to evidence that patient monitoring took place on one occasion. We asked the ward manager to explain how they were assured that staff were following the most up to date guidance in the use of rapid tranquilisation and they were unable to provide a clear explanation.

The ward did not have a seclusion suite. However, we identified from the incident data that in the reporting period between 27 April 2020 to 21 July 2020 there was one episode of a patient being secluded in their bedroom and another episode of a patient being segregated to one area of the ward. The staff had not identified either episode as seclusion or segregation and did not follow the guiding principles of the Mental Health Act Code of Practice and, where necessary, apply the Code's safeguards in relation to seclusion.

Safeguarding

Staff told us that if a patient came to harm by another patient or family member, they would raise this with the nurse. However, they did not identify that a patient coming to harm by staff on the ward would be escalated as a safeguarding concern. The four staff we spoke to were unable to give an example of when they had worked in partnership with other agencies to identify or protect patients at risk of harm. Only one member of staff we spoke to knew who the safeguarding lead was for the service.

In the three months prior to the inspection, we identified five incidents where a patient was exposed to risk of harm by staff on Pippin ward. None of the incidents we identified were reported by staff as a safeguarding referral. A safeguarding referral is a request from a member of the public, a professional or the police to the local authority to intervene and support or protect a child or vulnerable adult from abuse.

Reporting incidents and learning from when things go wrong

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

The hospital had introduced a new incident recording system three months prior to our visit. Staff told us that they were still unsure how to navigate the system to ensure that incidents were reported comprehensively.

We reviewed seven incidents during our inspection and found that a de-brief took place with the patient on two occasions. There was no evidence of family or carer involvement following incidents.

On all seven incidents we reviewed there was no evidence of any follow up action being identified to prevent similar incidents happening again. When requested, the staff could not provide us with any documented evidence of lessons being learnt following review of incidents.

None of the staff we spoke with were able to provide an example of changes being made as a result of feedback from an incident.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

During the inspection we reviewed three patient care records. Staff had completed a comprehensive mental health assessment of the patient in a timely manner on all records. We found care plans were personalised, holistic and updated when necessary. However, all the patient care plans we reviewed contained a copied and pasted assessment relating to COVID-19. This aspect of the care plan was not personalised or based on the individuals' physical health status. This was not in line with the providers policy on the use of personal protective equipment and COVID-19.

Best practice in treatment and care

Staff had completed initial physical health assessments for patients in all the records we reviewed, however we could only see evidence of ongoing physical health monitoring in one care record. Prior to our visit we had identified from incident data that one patient required a food and fluid chart to be filled in daily. We reviewed the food and fluid charts over a seven-day period during our visit. We found the chart had not been filled in on 15 of the allocated mealtimes, where the chart had been filled in, it stated that the patient had not accepted any food. An incident occurred whereby the patient collapsed, with staff failing to notice the patient had not eaten anything since their admission 10 days earlier. There was no evidence in the patients care plan to suggest that this had been referred to or followed up by a general practitioner or specialist.

Skilled staff to deliver care

Staff told us that they had not received any specific training when the patient group and ward changed from a rehabilitation unit to a psychiatric intensive care unit. When we arrived on site there were nine members of staff on duty. Only three members of staff were permanent and had been at the service longer than two months. The rest of the staff team were agency, bank or new to the service. Four of the staff had worked in the service less than two weeks. This meant that there were more new staff on shift than experienced workers. The manager told us they had been using more agency staff on Pippin ward to ensure they could open Bramley ward with experienced staff. This meant the most unwell patients were being cared for by staff who were new to the patient group and the service.

The percentage of staff that received regular supervision was 55%. The percentage of staff that had had an appraisal in the last 12 months was 53%. From the four staff we spoke to three of them told us that they received regular supervision. One staff member told us that they had not received supervision since November 2019. This is not in line with the providers supervision policy, which states that staff should receive a minimum of one supervision every three months.

Staff told us they had access to regular team meetings. However, the manager was unable to provide minutes of the meetings for us to review.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Kindness, privacy, dignity, respect, compassion and support

We spoke to nine patients as part of our remote Mental Health Act monitoring visit and inspection activity and received mixed feedback. The patients we spoke to on-site

were positive about the service, with one patient telling us the staff had "gone above and beyond" and another patient commenting that the "staff are lovely". However, during the remote Mental Health Act monitoring visit we carried out the week prior to the inspection one patient told us that "some staff are a bit brusque". Another patient said that some staff "shout at you". A further two patients told us that staff had sworn at them with one patient adding that a staff member belittles them.

We observed staff interactions with patients during our visit which were positive. We witnessed staff offering a patient extra clothing when they were cold and another staff member having a supportive discussion with a patient around her treatment plan.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Involvement in care

Staff told us that patients gave feedback on the service they received via surveys and weekly community meetings. We requested the results for the most recent staff survey; however, the service had not issued a survey to gather feedback since the service type and patient group had changed in April 2020. We requested the most recent community meeting minutes during our visit, the manager could not locate the meeting minutes and told us that a meeting had not taken place for the last three weeks on the ward. However, following the inspection the provider sent weekly meeting minutes for the duration of July, in which patients had been given the opportunity to provide feedback about the service.

From the three care records we reviewed we found evidence of patient involvement in two of them.

Involvement of families and carers

The service did not have a survey or community meetings in place for families and carers to provide feedback about the service. There was no evidence of families or carers attending multi-disciplinary meetings, or the service using technology to allow family members or carers to attend meetings, due to social distancing restrictions and COVID-19. We spoke to three carers during our Mental Health Act monitoring visit, the week prior to inspection, who all told us they were not invited to meetings.

We found from the care records that families and carers were able to have conversations with the staff including the doctor if they rang the ward for an update. However, there was no evidence of the service proactively involving families in the care of the patients.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs?

(for example, to feedback?)

We did not inspect the responsive domain as part of this inspection.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Leadership

Leaders failed to provide assurance that they had a good understanding of the service they managed. They could not explain clearly how the teams were working to provide high quality care. The ward manager was visible in the service and approachable for patients and staff. However, three of the four staff we spoke with were unaware of who the more senior managers were in the service.

Culture

Most of the staff we spoke with said they felt respected, supported and valued. However, one staff member told us they felt disrespected by other members of staff and felt they were treated differently to others. Two other staff members told us there was often gossiping on the ward and allegations of bullying. All staff felt able to raise concerns and knew how to use the whistleblowing process.

When we raised concerns with managers regarding the culture on the ward, they failed to assure us that they were taking all complaints and concerns seriously. They attributed the concerns to disgruntled staff following changes on the ward without conducting full investigations into the complaints.

Information we received prior to the inspection suggested that there were multiple members of the same family, and staff members who were in relationships working at the

hospital. We reviewed the staff rota for April – June 2020 and found that staff members who were related to each other were on shift together 12 out of 13 weeks. The Cygnet policy on 'recruitment, selection and appointment of staff' states that 'Each establishment will keep a register of employees who have relatives working at the same establishment and of employees who are related to individuals in our care. This must be kept up-to-date and be available for inspection by authorised persons at all times.' We asked for a copy of this register during our visit and the ward manager was unaware that this was part of their policy and did not have the register in place.

The policy also stated, 'It would also not be appropriate for an employee to supervise or line manage on a day-to-day basis another employee who is a relative.' On review of the rota and staff structure chart we found that staff in relationships were being directly managed by their partner or relative. This was not in line with the providers policy.

Governance

The hospital did not have robust systems in place to ensure that the wards were safe. Staff were not supported and did not receive specific training when the hospital changed to a psychiatric intensive care unit. Managers did not supervise and support staff in line with their supervision policy.

The staff did not receive comprehensive training in the use of their newly implemented incident recording system, which meant incidents were not fully captured. The hospital manager did not have robust systems in place to correctly review incident data to prevent patients from being at risk of harm. We asked the manager for specific information relating to five incidents on the ward. The manager was unable to provide any assurance that lessons had been learned and steps had been put in place to prevent further incidents happening. Managers failed to provide assurance that they had effectively acted on past incidents and risk.

The framework of what must be discussed at a ward, team or directorate level meeting was unclear. The manager could not provide documented evidence of what had been discussed in recent team meetings. The last clinical governance meeting minutes the manager could locate were from 7 May 2020. The meeting minutes stated that essential information could not be discussed due to their new systems "proving difficult". We requested a copy of their quarterly clinical governance meeting minutes for the period of April – June 2020, which evidenced that incidents had not been reviewed or discussed. We were unable to gather any evidence of lessons being learnt or shared.

Engagement

Managers had access to the feedback from patients, carers and staff and all staff felt they had the opportunity to feedback about the service. However, management failed to evidence how they had used feedback to implement change or make improvements in the service.

From the information we received on incidents prior to our inspection and the more detailed findings from our inspection, it was evident that that managers did not ensure openness and transparency with all stakeholders regarding their performance. We asked the manager how they planned to address this and they were unable to provide a clear explanation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all clinical staff have completed immediate life support training
- The provider must ensure that staff are carrying out physical health monitoring on patients following the use of rapid tranquilisation, in line with The National Institute for Health and Care Excellence guidance.
- The provider must ensure that staff follow their own policies and procedures in the ongoing monitoring of patients' physical health and ensure that systems are in place to support patients to access specialists when needed.
- The provider must ensure that all staff receive regular supervision and appraisal in line with Cygnet policy.
- The provider must put systems in place to ensure that all concerns raised with them are taken seriously, investigated fully and used to implement change within the service.
- The provider must take action to comply with the conditions imposed on their registration as part of enforcement action detailed in the enforcement section of this report.

Action the provider SHOULD take to improve

- The provider should ensure that staff always treat patients with respect and patient feedback is acted on to implement change.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: All clinical staff had not been trained in intermediate life support training as recommended by The Resuscitation Council (UK). Staff did not follow their own policies and procedures in ongoing physical health monitoring which resulted in a patient coming to harm. Staff were not monitoring patients following the use of rapid tranquilisation in line with The National Institute for Health and Care Excellence guidance. This was a breach of regulation 12 (1)(2)(a)(b)(c)

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 How the regulation was not being met: Managers did not act on all concerns raised with them. They did not complete full and thorough investigations into all concerns raised or have procedures in place to identify learning and implement change as a result of concerns being raised. This was a breach of regulation 17 (1)(2)(a)(b)(e)(f)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

Staff were not receiving supervision and appraisal in line with Cygnet policy

This was a breach of regulation 18(2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The service did not have a comprehensive environmental risk assessment in place that identified all ligature points and blind spots on the ward. Staff were unaware of all potential ligature risks on ward. In the three months prior to inspection we were notified of five incidents where a patient had been harmed or exposed to the risk of harm whilst on 1:1 observation. We reviewed the observation sheets for five different patients which had not been completed comprehensively or in line with Cygnet policy. Each had important information about patient care and level of risk missing from the written records, leaving patients exposed to the risk of harm. In the three months prior to the inspection, we had been notified of five further incidents where a patient was exposed to risk of harm. Managers could not evidence that they had considered and enforced the most up to date Public Health England guidance on using personal protective equipment; neither did they have their own systems for ensuring COVID-19 safety that were equal to or better than the guidance from Public Health England. This was a breach or regulation: 12(1)(2)(a)(b)(c)(d)(h)

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

This section is primarily information for the provider

Enforcement actions

How the regulation was not being met:

Managers did not have robust systems in place to correctly record and review incident data to prevent patients from being at risk of harm.

Following incidents, the management failed to evidence that lessons have been learnt and steps had been put in place to prevent further incidents happening.

Managers failed to provide assurances that they had effectively acted on past incidents and risk.

This was a breach of regulation: 17(1)(2)(a)(b)(c)(f)