Cygnet Woodside

Quality Report

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

Ratings

Overall rating for this location	**Inadequate**
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into 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.

Professor Ted Baker
Chief Inspector of Hospitals

Overall summary

We have rated Cygnet Woodside as inadequate because:

- We have taken enforcement action against the registered provider in relation to our concerns about this location. This limits our overall rating of this location to inadequate.
- Allegations of abuse towards patients were being investigated at the time of our inspection and there had been a delay in staff reporting allegations of abuse to managers. Senior leaders were not always fully sighted on concerns in the service including the allegations of abuse towards patients.
- The service had inherent risk factors and warning signs that increased the risk of developing a closed culture.
- Governance processes were not always effective, and we identified a range of areas that required improvement.
- Staff did not always adhere to government guidance and the service's Covid 19 risk assessment on wearing facemasks, bare below the elbows practices and tying back long hair.
- Staff did not follow good policies and procedures for use of observation in line with national guidance and did not record when patients were observed safe and well.
- Managers did not ensure that staff received an appraisal and supervision in line with the provider's policy. Team meetings had not taken place for at least three months.
- Staff did not always follow patients' activity and therapy plans or provide support in line with care plans and positive behavioural support plans.
- The service relied on bank and agency staff and there was a high turnover of regular staff. Shifts fell below the minimum numbers required and this had an impact on the ability to respond to incidents. Agency staff did not receive an induction.
- Staff had a basic understanding of safeguarding. Some staff previously had not raised concerns because they felt intimidated by other staff and some staff felt their concerns were ignored by managers.
- Incident reporting processes were not effective. Not all staff understood how to report incidents appropriately and staff did not report all the incidents that they should. Incidents were not always discussed at meetings to review patient risk and staff did not always receive a debrief and support following incidents.
- The service had areas that were not clean or well maintained, and the main ward area had a strong odour of urine.
- Restraint training provided to staff had not considered the physical ward environment and individual patients' needs and staff told us they did not always use correct restraint techniques.
- There were lapses in some patient records because staff did not always complete and keep patient risk

Summary of findings

assessments up to date, two records did not contain all the admission assessments required and one patient, whose discharge was delayed, did not have a discharge plan.
- Some patients had limited access to some communal areas of the hospital.
- Managers did not ensure the risk register clearly showed actions that were ongoing and those that were closed.
- The service did not notify us of a Deprivation of Liberty Safeguards application and authorisation.

However:

- Managers were open and transparent with patients and families when something went wrong.
- Most care plans were personalised, holistic and recovery oriented.
- Patients had access to information in accessible formats.

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 	

Summary of findings

Contents

Inadequate

Cygnet Woodside

Services we looked at
Wards for people with learning disabilities or autism

Summary of this inspection

Background to Cygnet Woodside

Cygnet Woodside is an independent mental health hospital providing an assessment, treatment and rehabilitation service for up to nine male adults with a primary diagnosis of learning disability, who may have behaviours that challenge or other associated complex needs. Patients are admitted formally under the Mental Health Act or under a Deprivation of Liberty Safeguards or informally with their informed consent. At the time of our inspection there were eight patients on the ward, seven patients were detained under the Mental Health Act, and one patient was subject to Deprivation of Liberty Safeguards and Court of Protection protocols. One of the patients detained under the Mental Health Act was on leave during the time of our inspection.

The hospital was registered with the Care Quality Commission in July 2011 to provide the following regulated activities:

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

• diagnostic and screening procedures

• treatment of disease, disorder or injury.

The hospital had a registered manager in post. 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.

We last inspected the hospital in May 2019. We rated this service as 'good' overall with ratings of 'good' in the effective, caring, responsive and well-led key questions and 'requires improvement' in the safe key question.

Following our last inspection, we issued the provider with two requirement notices in relation to breaches of the Health and Social Care Act. These were:

- Regulation 12 Safe care and treatment
- Regulation 18 Staffing.

We also told the provider what action it should take to improve. This was:

- improve the culture at the hospital
- ensure all staff have access to a personal alarm
- increase staff understanding of the Mental Health Act and its Code of Practice
- ensure that care plans reflect family and carers involvement.

Our inspection team

The team that inspected the service comprised three CQC inspectors and one Occupational Therapist Specialist Advisor. We undertook this inspection during the COVID-19 pandemic.

Why we carried out this inspection

We inspected this service following specific concerns about safety and culture.

Summary of this inspection

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

This inspection focussed on specific areas of concern, which meant that we did not inspect all the key questions.

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

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with the registered manager;
- spoke with 14 other staff members, including doctors, nurses and support workers
- received feedback about the service from commissioners and local authorities;
- attended and observed one staff morning meeting;
- spoke with five carers or relatives;
- looked at all eight care and treatment records of patients;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- we were unable to speak to patients directly, however, we did complete continuous observations of the care and treatment patients were receiving.

What people who use the service say

We spoke with relatives or carers of five patients.

Two carers told us that patients' physical appearance had worsened during their stay at Cygnet Woodside. Two carers said that patients' skills had decreased, and they could not do things they had been previously able to do before entering the service. One carer said that staff had discussed restraint in a derogatory manner and one carer said staff had said they did not know what to do with the patient.

Three carers told us that the management at the service were responsive to their requests and carers felt listened to. Two carers said the recent theme nights put on by the service had been good.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate 

We rated safe as inadequate because:

- We have taken enforcement action against the registered provider in relation to concerns about safety in this service. This limits our rating of this key question to inadequate.
- At the time of our inspection, there was an ongoing police investigation into allegations of abuse towards patients. There had been a delay in staff reporting safeguarding issues to managers.
- Staff did not always wear facemasks and the staff who wore facemasks did not always wear these properly. Staff were not bare below the elbow and did not have their hair tied back as required by the service's specific COVID-19 risk assessment. Staff did not follow good policies and procedures for use of observation in line with national guidance. They did not record the time that patients were observed to be safe and well and staff regularly undertook continuous observation for long periods of time in excess of the national guidance.
- Not all staff knew what incidents to report and how to report them. Staff did not report all incidents that they should report. Incidents from the incident management system report were not always discussed at the morning meeting.
- The service relied on bank and agency staff. There was a high turnover of staff at 42% and agency and bank staff had been used to cover 1799 shifts over 12 months. When agency staff were used, those staff did not receive an induction and were not familiar with the ward. The number of nurses and support workers on shift sometimes fell below the number required to meet patient observation levels. There was not always enough staff to ensure that patients could access leave regularly. When incidents happened, there were not enough staff available to respond to incidents because they could not leave the patients they were allocated to support.
- Night time cleaning records were not always completed, shower rooms had a build-up of residue on the surface and the main ward area had a strong odour of urine. Areas had damage to paintwork and the walls.
- Restraint training provided to staff had not considered the physical ward environment and individual patients' needs and staff told us they did not always use correct restraint techniques.

Summary of this inspection

- Staff did not always receive a debrief and support after incidents and there was no evidence of lessons learned from incidents.
- Staff did not always complete a risk assessment of every patient on admission or update it regularly, including after any incident.
- Although staff had received safeguarding training and had a basic understanding, they did not always act when needed.

However:

- There was medical cover day and night and a doctor could attend the ward quickly in an emergency.
- Staff understood the duty of candour. Management were open and transparent and gave patients and families a full explanation when they were aware that something had gone wrong.

Are services effective?

Inadequate

We rated effective as inadequate because:

- We have taken enforcement action against the registered provider in relation to concerns about effectiveness in this service. This limits our rating of this key question to inadequate.
- Staff did not always follow patients' activity and therapy plans or provide support in line with care plans and positive behavioural support plans.
- Administrators had not received training to enable them to perform their duties in line with legislation and guidance.
- No staff had an appraisal. Out of 43 staff, nine members of staff were overdue supervision and 12 staff had not had four supervision sessions in the last 12 months. This fell below the provider's target.
- Two out of eight patient records did not contain all the physical health assessments on admission required.
- Managers did not ensure that staff had access to regular team meetings and there was no evidence of lessons learnt.

However:

- Most care plans were written to a high standard and were personalised, holistic and recovery oriented.
- Staff met regularly to hold multidisciplinary team meetings.

Are services caring?

We have suspended the rating of the key question 'caring' at this location.

Summary of this inspection

We did not inspect the key question 'caring' at this inspection. This means that caring is not rated.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Despite the hospital stating it provided assessment, treatment and fast stream rehabilitation, five out of the eight patients had their discharges from the hospital delayed. One of these patients did not have a discharge plan despite their length of stay exceeding five years.
- Some patients had limited access to communal areas of the hospital because other patients had identified areas of the hospital as their own personal space.

However:

- Patients had access to information in accessible formats that they could understand and were able to use to communicate with staff.
- Patients had a choice of food to meet their dietary requirements including religious beliefs and ethnic groups.
- Patients had somewhere secure to store their possessions, could meet visitors in quiet areas of the ward or a visiting room and could make phone calls in private.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- We have taken enforcement against the registered provider in relation to concerns about governance in this service. This limits our rating of this key question to inadequate.
- A range of governance processes were not effective. We identified concerns that include but were not limited to poor cleanliness and maintenance, staff supervision, appraisal, debriefs following incidents, adherence to government guidance on infection prevention control measures, incident reporting and patient observations.
- The service had inherent risk factors and warning signs that increased the development of a closed culture. There was also an ongoing police investigation into allegations of abuse towards patients. Senior leaders were not always fully aware of concerns in the service and this included a concern relating to allegations of abuse towards patients.
- The service had a high rate of staff turnover and high agency usage. Agency staff did not always receive an induction or information about patients they were supporting.

Summary of this inspection

- Some staff told us that they had not raised concerns previously because they felt intimidated by other staff and some staff felt their concerns were ignored by managers.
- Managers did not ensure the risk register clearly showed actions that were ongoing and those that were closed.
- The service did not notify us of a Deprivation of Liberty Safeguards application and authorisation.

However:

- Leaders were visible in the service and approachable for patients and staff.
- Some staff we spoke to said they felt respected, supported and valued. Some staff felt positive and proud about working for the provider and their team.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

We did not review the provider's compliance with Mental Health Act responsibilities during this inspection.

We last undertook a Mental Health Act review visit of the service in December 2018. At that visit, we raised six actions for the provider to take to be compliant with the Mental Health Act and its code of practice. The provider submitted a provider action statement to us to explain the action they planned to take to meet these actions.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review the provider's compliance with the Mental Capacity Act during this inspection.

However, we did find that the service had not submitted one statutory notification of a Deprivation of Liberty Safeguards outcome to us.

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	N/A	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	N/A	Requires improvement	Inadequate	Inadequate

Notes

Inadequate

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

Safety of the ward layout

The ward layout did not allow staff to observe all parts of the ward, but continuous supervision of patients mitigated the risks. Six out of the eight patients in the hospital always required at least one staff member with them. There were four patients that always required two staff with them, two patients that always required one staff member with them and two patients on general observations with one staff member required to support for personal care.

The ward complied with the Department of Health guidance on eliminating mixed sex accommodation because it was a male only ward.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff carried call alarms and we saw these working during our inspection. However, after our onsite inspection we received a safeguarding alert where we were informed that an alarm had not been used when a staff member had secluded a patient in their ensuite bathroom.

Maintenance, cleanliness and infection control

Ward areas were not clean, the ward areas did not have good furnishings and were not well-maintained or fit for purpose. The hospital had two floors and all patient bedrooms and bathrooms were on the first floor on a long and narrow corridor. Staff told us that the bedroom corridor was too narrow, and this made it difficult to support patients safely. Staff spent prolonged hours standing on continuous observation in these areas, usually for 6 hours. During our inspection, we saw that the ward areas had damaged walls and damaged paintwork in places and intermittent issues with the television. However, the service provided us with a programme of works that were to be completed by January 2021. The programme of works included new flooring in the dining room, conservatory and quiet room, and a full refurbishment of a shower room, the bedroom corridor and the quiet room. CCTV installation work across the site was due to start on the 22 September 2020. The service told us that on 9 October 2020 CCTV was operational in the service.

Day time cleaning records were up to date, but night time cleaning records did not demonstrate that the ward areas were cleaned regularly. Shower rooms were dirty with a build-up of residue on the surfaces and there was a strong odour of urine in the main ward area. An auxiliary staff meeting for domestic staff held in August 2020 noted that there were gaps in the cleaning records and the minutes said the ward did not look clean after a night shift. We requested cleaning audits from the service, but they were not provided.

Staff did not adhere to infection control principles. Staff were not following guidance on the use of personal protective equipment and infection prevention and control during the COVID-19 pandemic. National guidance implemented in June 2020 and updated in August 2020 for all healthcare settings required the extended use of facemasks by all staff in both clinical and non-clinical areas within healthcare settings. During our visit on 15 September 2020, the registered manager told us that staff were exempt from wearing facemasks at this service because this was distressing for patients. However, when

we visited the service on 23 September 2020, the provider had mandated the use of facemasks for staff except for where this distressed individual patients. We saw most staff did not wear a facemask. Some staff wore masks incorrectly under their nose or at their chin. The service did not provide risk assessments to show that staff had a clinical reason for not wearing a facemask or risk assessments to show that individual patients could not tolerate staff wearing facemasks. Staff were not bare below the elbow and did not have their hair tied back as required by the service's specific COVID-19 risk assessment. During our inspection, we were informed that one member of staff had tested positive for COVID-19 and three staff were isolating due to contact with the confirmed case.

Safe staffing

Nursing staff

Key staffing indicators

Between 1 September 2019 and 31 August 2020, the service reported the following information on staffing:

The service establishment level was for four whole time equivalent registered nurses and 30 whole time equivalent support workers.

There were no vacancies for registered nurses or support workers.

There were no shifts left unfilled.

However, there was a high turnover of staff at 42% and agency and bank staff had been used to cover 1799 shifts over 12 months. Despite the provider reporting that there were no vacancies, the amount of bank and agency staff used remained consistent throughout the 12 months.

The average staff sickness rate was 7%.

Managers had calculated the number and grade of registered nurses and support workers, but this was not enough for the required level of support. The service calculated a daily requirement of 12 support workers, one team leader, and one registered nurse for day shifts. Five support workers and one nurse were required for the night shift. The service told us that a second registered nurse was brought in one day a week for the multidisciplinary meeting. The high level of support required to meet the assessed needs of patients meant this was not enough staff.

The number of registered nurses and support workers on duty did not always match the number planned on all shifts. Despite the provider reporting that there were no shifts not filled, we reviewed rotas for 14 to 27 September 2020 and found that seven out of 14 day shifts fell below the minimum staffing levels. There were three day shifts where there had only been nine support workers. On two day shifts there were no team leaders. A night shift did not have enough support workers.

The registered manager could adjust staffing levels daily to take account of case mix. Ward rotas from June 2020 to September 2020 showed that the number of staff required had changed and the manager told us that they had the ability to change staffing levels if needed. However, we saw that there was not always enough staff available to fill the planned staffing requirements.

Patients did not always have regular time with their named nurse. Some staff told us that patients should meet with their named nurse once a week, but this did not always happen due to staff shortages.

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. The service had used bank staff 500 times and agency staff 1299 times to cover shifts from September 2019 until August 2020. This meant bank and agency staff were covering 37 shifts a week on average. This was an increase since the last inspection in May 2019 where bank and agency staff covered an average of 21 shifts per week between 01 January 2018 to 01 January 2019. The service had suspended several staff members in September 2020 due to allegations of abuse towards patients and increased use of agency staff was added to the service's local risk register as an ongoing risk.

When agency staff were used, they did not all receive an induction and were not all familiar with the ward. We observed two agency staff members on their first and second shifts at the service working with patients on a continuous support and engagement basis who had not received any training on the service or the patients they were supporting. An agency staff member reported to us after the inspection that they had not been given information about the service or the patients they were supporting. The provider failed to respond to our request for the agency induction process. The service told us that bank staff received an induction and were familiar with the ward. The service used a health care induction book and

the registered manager told us that bank staff had been at the service for a long period of time. However, there was no assurance that these were completed for all bank staff. We reviewed one induction book and found that no dates were given for when tasks were completed or a staff signature to confirm each task had been completed.

A registered nurse was always present in communal areas of the ward. Although staff reported that escorted leave and ward activities were not cancelled due to staff shortages, staffing data showed there were limited numbers of staff to ensure that regular leave could be accessed by patients. Our observations during inspection also showed that staff did not always offer or carry out the activities and therapies planned for patients within the hospital. Some staff told us that there were not enough drivers to support escorted leave. However, two carers told us they were happy with the amount of activities the patients were given access to.

There were not always enough staff available and trained to carry out physical interventions safely. Due to the level of observations that patients required, this meant that there were not always enough available staff to respond to incidents because they could not leave the patients they were allocated to support. Rotas also showed there was not always enough staff to meet the minimum staffing levels. Some staff told us that they were fearful that they would be unable to get support from other staff if multiple incidents happened at the same time. Three care records did not have restraint plans in place as per the provider policy. A restraint trainer visited the site on a regular basis to discuss appropriate restraint techniques. Some staff told us that the approved restraint techniques they are taught were not realistic for the building as the bedroom corridor was narrow and the high number of staff on the corridor meant that space was limited. Some staff also told us that the number of restraints required without rotation of staff on continuous support could lead staff to be burnt out and not carry out the correct restraint holds. There had been a recent safeguarding issue raised alleging that staff had used an unapproved restraint technique. This was reported to the leadership team who suspended the member of staff, raised a safeguarding concern and reported the incident to the CQC.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. The service shared emergency on call cover with three other services within the region. The service told us that they had not had to call upon the out of hours on call cover for the last 12 months.

Mandatory training

Most staff had received and were up to date with all the appropriate mandatory training. The manager told us that some courses could not be completed due to restrictions on face to face training as a result of the social distancing measures required due to the COVID-19 pandemic.

Overall, staff in this service had undertaken 86% of the various elements of training that the service had set as mandatory. The provider reported the following compliance rates:

- Foundation management of actual and potential aggression 94.2%
- Advanced management of actual and potential aggression 80%
- Adult basic life support and automated external defibrillation 80%
- Equality and diversity 92%
- Immediate life support and automated external defibrillation 66%
- Information governance 90%
- Health and safety 88%
- Responding to emergencies 84%
- Safeguarding 90%
- Dealing with concerns at work 94%
- Food safety 90%
- Infection control 92%

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed eight care records and most demonstrated good practice. There were easy read documents for the patients and guidance on how to involve the patient in their care planning. Positive behaviour plans were comprehensive, described behaviours specific to each patient and provided with guidance for staff on individualised techniques to support patients effectively. However, two patients were missing multiple assessments on admission, one patient's care and treatment review meeting document could not be located, and we found

gaps in one patient's food chart. Three care records did not have restraint plans in place as per provider policy. Our observations showed that staff did not always follow patients' care plans.

Staff used a recognised risk assessment tool. The service used the START (short-term assessment of risk and treatability) tool which was reviewed every 3 months. However, staff did not always complete a risk assessment of every patient on admission or update it regularly, including after any incident. One patient had a choking risk assessment that was to be reviewed every four months but had not been reviewed since April 2019. One patient could only be restrained for a specific time period due to health reasons, but this was not documented in their care plan and staff provided different lengths of time they recalled the patient could be restrained. This ranged from five minutes to 15 minutes. Not having up to date and comprehensive risk assessments could lead to avoidable harm.

Management of patient risk

Staff sometimes identified and responded to changing risks to, or posed by, patients. A daily risk assessment meeting was held each day to review patient incidents over the previous 24 hours. However, not all incidents were reported on the incident management system were discussed in the morning meeting and incidents discussed had not all been reported on the incident management system. The meeting decided the level of risk of each patient. This meant that the daily risk assessments completed may not be accurate because staff at the meeting were not aware of all the incidents that had happened when reviewing and assessing patient risks.

Staff did not follow good policies and procedures for use of observation. Staff did not maintain accurate and contemporaneous records of patient observations and staff were allocated to continuous observations for longer than two hours routinely without breaks. The form that the service used to record patient observations during the day time did not have a requirement for staff to record the time when patients had been checked to ensure they were safe and well. It only required staff to provide an overview narrative of the patient's activity for the shift. Two of the eight patients only required general or intermittent observations and their records did not show when patients had been observed to be safe and well in line with their observation levels. At night time, for all patients a document created by the service was used to record hourly observations. The form was pre-printed with the times so this was not a record of the actual time that patient observations were completed. The Mental Health Act Code of Practice 2015 (26.31) states, "enhanced observation may be provided on an intermittent basis with staff engaging with patients and observing their condition at irregular and unpredictable intervals of between 15 and 30 minutes." One patient required 15-minute observations throughout the night, but the document used only recorded hourly observations so there was no evidence that staff had completed observations every 15 minutes. The National Institute for Health and Care Excellence Guidance; Violence and aggression: short-term management in mental health, health and community settings NG10 guidance states providers should, "Ensure that an individual staff member does not undertake a continuous period of observation above the general level for longer than 2 hours". Staff were regularly allocated to support patients continuously for durations from three and a half hours up to six hours before being rotated to another patient's observations for a similar length of time. One member of staff told us it was possible to be on continuous observations for up to 12-13 hours. We observed multiple staff members on both days of our inspection stood in the bedroom corridor for prolonged periods of time. Records showed that staff did not always take breaks during 12-hour shifts.

Staff applied restrictions when justified. The service had a reducing restrictive practice plan that had been reviewed on 8 September 2020. Restrictions included cans, plastic bags and access to the activities of daily living kitchen. Patients' access to the activities of daily living kitchen was individually risk assessed for each patient. Bottles and hessian bags were used as alternatives to cans and plastic bags.

There was no seclusion room at the hospital. However, there was evidence that staff had secluded patients in other areas of the hospital which was against provider policy.

Use of restrictive interventions

In the 12 months before the inspection:

There were 404 episodes of restraint used on 10 patients and two uses of rapid tranquilisation. This was an average of eight restraints per week over the year. This was an

increase from the previous restraint data from the last inspection in May 2019 which had an average of five restraints per week from 01 July 2018 to 31 December 2018.

Staff told us they did not always use correct restraint techniques. Some staff said they struggled to use the correct techniques due to the size of the ward areas, such as the bedroom corridor. Some staff also said the length of time on continuous observations paired with the high number of restraints required meant that staff did not always use the correct holds as they were tired. At the time of our inspection, there was an ongoing police investigation relating to allegations of abuse against a patient.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, institutional and neglect.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Although staff had received safeguarding training and had a basic understanding of how to identify adults and children at risk of, or suffering, significant harm, they did not always act when needed. Between August 2019 and August 2020, the service made 22 safeguarding referrals to the local authority relating to nine different patients. Of the 22 safeguarding referrals, four related to alleged abuse towards patients. There were two additional safeguarding concerns from family members about alleged abuse towards patients. Staff said they knew how to identify abuse and were aware of the reporting procedures. However, not all staff raised a safeguarding alert when appropriate. At the time of our inspection, there was an ongoing police investigation relating to allegations of abuse towards a patient and there had been a delay in staff reporting this to managers.

Staff access to essential information

Staff used a combination of paper and electronic patient records.

All information needed to deliver patient care was mostly available to all relevant staff when they needed it and was in an accessible form. However, agency staff told us that they had not been told this information was available to them or how to access it.

If staff were expected to record information in more than one system (paper or electronic), this did not cause them any difficulty in entering or accessing information.

Track record on safety

There had been no serious incidents reported by the service in the last 12 months. There were no unexpected deaths reported by the service.

Reporting incidents and learning from when things go wrong

Staff did not report all the incidents that they should have and not all staff knew what incidents to report and how to report them. We identified multiple cases where staff had not reported incidents using the incident reporting system. These included incidents recorded in patients' progress notes that had not been reported on the service's incident reporting system. There had been a safeguarding issue raised in relation to allegations of abuse towards a patient in a patient's care programme approach meeting minutes but there was no record of this incident in the patient's daily notes. We also observed a morning meeting where three incidents were discussed and none of these had been reported on the incident reporting system. Care plans that we reviewed noted in June 2020 and July 2020 four incidents for two patients that had not been reported on the incident reporting system. We also requested body maps (used to indicate areas of injury or marks on a person's body) from the service, but these were not provided. However, these were provided at the stage of factual accuracy after the inspection period. Staff advised that all incidents must be discussed at the morning meeting where the multi-disciplinary team assessed the level of risk for the patient that day. We found that incidents from the incident reporting system were not always discussed at the morning meeting. This meant that staff reviewing and assessing risk were not aware of all the incidents in order to complete an accurate assessment.

Inadequate

Wards for people with learning disabilities or autism

The incidents that had been reported did not contain all the key information such as time of incident, type of restraint used, and incident outcome. There was no evidence of learning from when things go wrong being passed on to staff.

Staff understood the duty of candour. Management were open and transparent and gave patients and families a full explanation when they were aware that something had gone wrong. The manager of the service did inform all families of the patients affected by allegations of abuse towards patients. Three carers said that the management team were responsive and open.

Staff were not always debriefed or received support after incidents. The provider could not provide evidence of the last three months debrief information to us. Staff told us that debriefs were informal and did not always happen for staff or patients. Some staff also told us that the space on the incident form for recording debriefs was not large enough to capture all relevant information.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

Staff did not always assess patients' physical health needs in a timely manner after admission. We reviewed eight care records. One patient record had no medical assessment or physical assessment on admission and one patient had no nursing or medical assessment at admission.

Staff developed care plans that met the needs identified during assessment. Most care plans were personalised, holistic and recovery-oriented and staff regularly updated these. Staff included patient views when developing care plans. Care plans contained details of meaningful and purposeful activity for each patient including any sensory needs, spiritual needs and cultural needs. Records contained individualised and comprehensive positive behaviour plans. The service had also produced a one-page positive behaviour plan and easy read versions of care plans were available. However, agency staff told us they had not been provided with information about patients they were supporting, and we did not observe staff providing support in line with patients' care plans.

Best practice in treatment and care

Staff did not provide a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. During our inspection, there was no meaningful activity for most patients. A comparison of patients' activity planners showed that none of the activities were being completed. Patients spent a long time in their bedrooms alone whilst staff stood outside their bedroom in the corridor. Agency staff were not aware that activities were part of their role. Two carers told us that patients' level of function had decreased since being in the service. Two clinical commissioning groups said the service was not responsive to the needs of patients and there were gaps in care. However, the occupational therapist, who worked at the service three days a week, had completed assessments on patients' access to the activities of daily living kitchen and patients' sensory needs.

Skilled staff to deliver care

The team included or had access to the full range of specialists required to meet the needs of patients on the ward. The multi-disciplinary team comprised of one consultant psychiatrist, one occupational therapist, one clinical psychologist, two assistant psychologists and one speech and language therapist. Except for the two full time assistant psychologists, the other multi-disciplinary team members all worked part time hours. The consultant psychiatrist was contracted for 16 hours per week, the clinical psychologist for 24 hours per week and the occupational therapist and speech and language therapist worked three days per week. We were also told by some clinical commissioning groups that they had concerns over the minimal amount of time the specialists spent at the service and some staff told us that the service would benefit from the multidisciplinary team being at the service more often.

The service offered a one-off autism training session to all staff and staff then had access to update training via the learning disability module. However, training in learning disabilities and autism was not provided routinely to staff. There were five patients with autism at the service. Out of

43 staff members, 14 had not received training in autism in over 16 months and two staff members had not received any training in autism. There was no training provided to staff in learning disabilities. The administrators at the service had not received training on the Mental Health Act or the Mental Capacity Act and Deprivation of Liberty Safeguards but were provided support by the Mental Health Act administrator from another service. The administrator role was to administer the documents and follow up on actions in relation to these legislations.

We received 43 staff records during the inspection period and of those, none had been completed in the year previous to inspection There were 14 members of staff who were past their appraisal due date.

Staff did not receive regular supervision. The service policy stated that regular supervision should be four times per year. We reviewed staff records of 43 staff members. Between August 2019 and August 2020, nine out of 43 staff supervision records we reviewed showed that supervision was overdue and 12 out of 43 staff had not received four supervision sessions in the last year. Lack of supervision and appraisal meant that management were unable to know if the staff were providing appropriate care and treatment or required additional support

Managers did not ensure that staff had access to regular team meetings. The service told us that team meetings did not happen in June, July or August 2020. Managers told us that information was sent to staff via their provider e-mail addresses but advised that e-mail accounts could only be accessed in the nurse's office.

Managers did not deal with poor staff performance promptly and effectively. At the time of our inspection, there was an ongoing police investigation relating to allegations of abuse towards patients. The registered manager told us details of measures in place to mitigate a potential ongoing risk towards patients; however, we saw that this was not being followed in practice. We raised concern at the end of our inspection and the provider took additional action to mitigate this risk.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings. The service held a multidisciplinary meeting every week. The meetings were attended by psychology, psychiatry, nursing, speech and language therapy and the care coordinator and family were also invited. The service brought in an additional nurse on this day to ensure there was a nurse presence on the ward.

Staff did not share all the information about patients at handover meetings within the team (for example, shift to shift). At the start of each shift, handover meetings were held by the nurse from the previous shift. The meetings were held twice a day, once in the morning and once in the evening. Handover documents from August 2020 had multiple gaps of information missing including staff signatures, who gave the handover and who received it, staff allocation, who the manager on call was and patient notes. This meant there was not always a record to confirm that patient information had been received by the staff caring for them.

Are wards for people with learning disabilities or autism caring?

The CARING domain was not rated.

Kindness, privacy, dignity, respect, compassion and support

Whilst on inspection at the service and staff knew we were present, we observed some staff interacting with patients which was respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. However, some staff were on continuous observations and stood on the bedroom corridor whilst the patients were in their bedrooms.

Staff did not always understand the individual needs of patients. Some agency staff had not been formally inducted to the service and had not been made aware of the patient needs.

Staff told us they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. However, there was an ongoing police investigation relating to allegations of abuse towards patients and some staff members had not raised concerns with management because they felt intimidated by other staff in the team.

Involvement in care

Involvement of patients

Inadequate

Wards for people with learning disabilities or autism

Staff found effective ways to communicate with patients with communication difficulties including patient use of communication cards.

Staff did not enable patients to give feedback on the service they received. There were no community meetings or patient surveys.

Staff ensured that patients could access advocacy. The independent mental health advocate told us that the service sent weekly patient updates to the advocate and encouraged relatives and carers to contact the advocate if needed.

Involvement of families and carers

Some carers told us that staff informed and involved families and carers appropriately and provided them with support when needed. However, some families and carers said they were not happy with how staff had spoken to them about the patient's treatment.

Staff enabled families and carers to give feedback on the service they received. There had been a relatives and carer survey completed by four carers but there was no date on the forms to say when this had been completed.

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

Requires improvement

Access and discharge

Discharge and transfers of care

The hospital aimed to provide assessment, treatment and fast stream rehabilitation. There were five patients who had their discharges delayed. The longest length of stay started in May 2015, three patients were admitted to the service during 2017 and one patient had been admitted in May 2018. The service told us that the five patients' discharges were delayed due to clinical commissioning groups being unable to find appropriate placements for the patients to transition to.

One out of the five patients who had their discharges delayed from the service did not have a discharge plan in place. This patient was admitted to the service in 2015 and there was no information relating to planning for discharge in the patient's care records or consideration of discharge planning during the last three months of multi-disciplinary meetings. The service had also recently received a complaint from a local commissioning group as they had felt that the service was not supporting the transition of a patient sufficiently.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms which they could personalise; however, personalisation of the bedrooms was variable. Three patients' bedrooms had no personalisation. One of these patients was on section 17 leave which meant they were on leave from the service as authorised by the responsible clinician. None of the bedrooms had chairs for patients or support staff to sit on. Two bedrooms did not have curtains up, but we saw these were folded in the room if a patient wanted them putting up. One bedroom did not have any curtains available; however, there was frosting on the windows for privacy and dignity. One patient had made a communal lounge into their sleeping area. The multidisciplinary meeting minutes noted this was a concern and were trying to support the patient to sleep in their bedroom.

Patients had somewhere secure to store their possessions. Wardrobes and tables in the patient bedrooms were lockable. The bathroom cabinets in the two ensuite bathrooms were also lockable. Patients were risk assessed for access to keys.

Staff and patients did not have access to the full range of rooms and equipment to support treatment and care. We observed and were told by staff that some patients had claimed communal rooms for themselves. This meant that other patients were not allowed to access these rooms, which limited the communal areas available for other patients to use.

There were quiet areas on the ward and a room where patients could meet visitors. Staff told us that visitors could meet with patients in multiple locations including patient bedrooms, the visitor room, or the garden dependent on what the patients wanted.

Patients could make a phone call in private. The patients were able to make phone calls in their bedrooms.

Inadequate

Wards for people with learning disabilities or autism

Patients had access to outside space. However, the outside space was small, and one carer said it wasn't large enough for patients' needs.

Patients relied on staff to make drinks and snacks 24/7. None of the patients had individual access to the activities of daily living kitchen, which was locked as all patients had been individually risk assessed as not safe in the kitchen. Staff offered patients drinks and snacks regularly and made these for patients on request. Patients could only access drinking water with the support of a staff member.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients by ensuring disabled people's access to premises and by meeting patients' specific communication needs. The service was wheelchair accessible and had an elevator available to transition from the ground floor to the first floor where the bedrooms and bathrooms were located.

The information provided was in a format accessible to the patient group. The care records all had easy read documentation available for the patients. Information displayed around the service was in accessible formats and patients had access to easy read copies of their care plans. Some patients had individualised communication cards to aid their communication.

Staff made information leaflets available in languages spoken by patients. A sign was displayed that was written in different languages. The sign explained to patients how to access more information in their first language.

Managers ensured that staff and patients had easy access to interpreters and/or signers. There were no patients on the ward who required interpreters and/or signers, but the service could access this if required.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. Care plans detailed dietary requirements for each patient.

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

Inadequate

Leadership

We identified multiple issues in the service which raised concerns about leadership and governance within the service. There was also an ongoing police investigation relating to allegations of abuse towards patients and we were concerned that senior leaders were not fully aware of this until we raised this with them.

Leaders did not have a good understanding of the concerns, risks and issues in the service they managed. There were concerns relating to allegations of abuse towards patients which was being investigated at the time of our inspection. Prior to these concerns being reported leaders were unaware of concerns in the service. We observed that staff were not following patients' positive behavioural support plans or activity plans. Agency staff did not receive an induction and had not received information relating to patients that they were supporting.

Leaders were visible in the service and approachable for patients and staff. We observed, whilst on inspection, both the Head of Care and the Registered Manager on the ward, talking to patients and staff. Three carers told us that the management at the service were responsive to their requests and they felt listened to. However, some staff told us that concerns they had raised about the service had not been dealt with by management.

Culture

The service had risk factors and warning signs that increased the risk of the development of a closed culture. Closed cultures can lead to harm, which can include human rights breaches such as abuse towards patients. The service had inherent risk factors and warning signs. These included patients that were highly dependent on staff to meet their basic needs and less able to speak up for themselves without good support. The service had also high turnover of staff, there were staff shortages at times and regular high use of agency staff that did not receive an induction to the service or information about the patients they were supporting. There was a lack of specialist training in learning disabilities and autism to ensure staff had the right skills, staff did not receive regular supervision or appraisals and team meetings had not taken place for at least three months. Due to the commissioning arrangements and during the COVID-19 pandemic there was limited monitoring oversight from visiting

professionals, family and friends. Although staff told us they felt able to raise concerns without fear of retribution, some staff had not raised concerns with management because they felt intimidated by other staff in the team.

Staff did not always report incidents and those reported were not always reported accurately. Staff undertook continuous observations for long periods of time without breaks in excess of national guidance.

Some staff we spoke to said they felt respected, supported and valued. However, some staff said they felt their concerns were ignored by management.

Staff felt positive and proud about working for the provider and their team. However, staff told us that the recent police investigation into concerns relating to allegations of abuse towards patients was stressful and had caused friction within the team.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. Following the recent allegations regarding some staff behaviour towards patients, the Freedom to Speak Up Guardian had visited the service. The service had also arranged for a human resource drop in event for staff to attend. All staff we spoke to said they would be comfortable raising concerns or following the whistle-blowing process.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively. Performance and risk were not managed well. Overall the supervision of staff was below the provider's target and specialist training was minimal. No staff had received an appraisal in the last year. The service was heavily reliant on the use of agency and bank staff. There were multiple gaps in documentation including handover documents, cleaning records, and care records. The use of personal protective equipment was not adequately followed during the COVID-19 pandemic. Continuous observations were longer than the national guidance and the observation forms that were used did not ensure that all patients were seen safe and well at agreed observation times. The administrators at the service had not received training in the Mental Health Act or Mental Capacity Act and a statutory notification for Deprivation of Liberty Safeguards had not been submitted to us. Staff understanding of incident reporting was variable and there were multiple gaps in incident documentation. Leaders did not follow their own providers policy on recruitment in relation to the interview panel and records.

There was not a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Team meetings had not happened for the last three months.

Management of risk, issues and performance

Senior staff maintained and had access to the risk register. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register. However, the risk register had not been fully updated. Risks dating back to 2018 remained on the risk register and although there was information recorded about action taken, it was not clear when actions had been completed or closed. Managers advised us some of these risks had been concluded.

Information management

Staff did not always make notifications to external bodies as needed. One Deprivation of Liberty safeguards application and authorisation had not been submitted to the Care Quality Commission as a statutory notification as required.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that patient care plans are implemented to meet the assessed needs of patients. (Regulation 9 (1) (a) (b) (c) (3) (b) (e) (h))
- The provider must ensure that all staff use personal protective equipment as required by Caireach Limited policy and in compliance with national guidance. Where required, staff must have individual risk assessments relating to the use of personal protective equipment. (Regulation 12 (1) (2) (a) (b) (h))
- The provider must ensure that all patients have free access to drinking water. (Regulation 9 (3) (i))
- The provider must ensure that patient observation records are maintained to document when all patients are seen safe and well during the day and night. (Regulation 17 (1) (2) (c))
- The provider must ensure that continuous patient observations are completed in line with national guidance. (Regulation 12 (1) (2) (b))
- The provider must ensure that all staff understand and follow the incident reporting policy. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure that there are enough staff to meet patients' needs and keep them safe. (Regulation 18 (1))
- The provider must ensure that all staff, including agency staff, receive a robust and comprehensive induction to the service and patients. (Regulation 18 (1) (2) (a))
- The provider must ensure that robust governance arrangements are in place to ensure the risk of harm to patients is mitigated. (Regulation 17 (1) (2) (a) (b) (e) (f))
- The provider must ensure that all staff are provided with formal debriefs following incidents and this is documented. (Regulation 17 (1) (a) (b) (c) (e))
- The provider must ensure that all patient assessments and risk assessments are completed and up to date. (Regulation 17 (1) (2) (b) (c))
- The provider must ensure that all patients have up to date restraint care plans and restraint training considers the design and layout of the building and individual patient needs. (Regulation 17 (1) (2) (a) (b) (c) (e))
- The provider must ensure that all staff receive regular supervision and appraisal in line with the provider policy. (Regulation 18 (2) (a))
- The provider must ensure that all staff are given the opportunity to attend regular team meetings. (Regulation 17 (1) (2) (a) (b) (e))
- The provider must ensure that all recruitment interviews follow provider policy. (Regulation 17 (1))
- The provider must ensure that handovers are completed in line with provider policy and documentation kept up to date. (Regulation 17 (1) (2) (a) (b) (c))
- The provider must ensure that the hospital is well maintained and cleaned regularly. (Regulation 15 (1) (a) (e) (2))
- The provider must ensure that they notify the Care Quality Commission of all Deprivation of Liberty Safeguard applications and authorisations. (Registration Regulation 18 (4))

Action the provider SHOULD take to improve

- The provider should ensure that they review and work with other agencies for the patients who are on delayed discharge. (Regulation 9)
- The provider should review staffing establishment levels to ensure that there are enough regular staff to meet the minimum safe staffing levels. (Regulation 18)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing