Cygnet Yew Trees

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?	Good
Are services caring?	Requires improvement
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

This service was placed in special measures in 20 December 2019. Insufficient improvements have been made such that there remains a rating of inadequate for any core service, key question or overall. Therefore, we are taking 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 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 Edward Baker

Chief Inspector of Hospitals

Overall summary

Cygnet Yew Trees is a 10-bed hospital, which provides care and treatment for women aged 18 years and above who have a learning disability.

We rated Cygnet Yew Trees as inadequate because:

- The provider did not ensure that there was adequate leadership and oversight of the safety and quality of the service. It had not made the required improvements that we told them were needed at previous inspections in relation to a section 29 warning notice.
- The provider did not address concerns related to staff ensuring the safe observation of patients and completion of accurate records.
- The provider did not ensure adequate governance structures, processes and systems of accountability for the performance of the service. We identified risks with the provider's systems for assessing and monitoring of staff appraisal and supervision, response to complaints, the workforce race equality standards, and the accessible information standards.
- Despite being a hospital for women, from November 2019 to January 2020, only 40% of staff were female. This meant that there were often insufficient female staff to support patients with personal care needs.

At this inspection we also found:

- The provider did not have systems in place to ensure the effective sharing and implementation of policies such as physical health policy, epilepsy care pathway and their 'engagement and observation policy' to ensure all staff knew how to respond should a patient experience a seizure. Staff were not ensuring relevant patients' care plans detailed how to keep patients who might experience a seizure safe in line with The National Institute for Health and Care Excellence 'Epilepsy in adults Quality standard [QS26]'.
- We identified further risks as staff did not fully follow the provider's systems for responding to complaints.
- The provider did not ensure that staff had easy access to essential information. We received conflicting information from staff about where the up to date care plans and risks assessments were for patients, therefore not all staff on duty knew where to locate information.
- The hospital had insufficient space for the number of complex patients with challenging behaviour. The staffing levels required to undertake patient observations made the environment crowded. There was limited quiet space for patients or staff to use for de-escalation. There were a number of incidents where patients were violent and aggressive towards staff or other patients, affected by the lack of space.
- The provider could not demonstrate that (where relevant) staff had supported, informed and involved

Summary of findings

families or carers in patients' care and treatment. Carers told us that staff did not always effectively communicate with them and they were not involved as much as they would like in patients' care.

- The provider currently had eight of 10 patients with delayed discharges. Staff spoke with us about the challenges of working with commissioners to find and fund suitable placements outside of the hospital. The average length of stay at the hospital was three years. This is an increase since our April 2019 inspection (782 days) and above the national average (554 days source: Learning Disability Census Further Analysis: England 2015).

However:

- The provider was bringing the hospital and other local hospitals in the Cygnet group under one-line management 'healthcare' structure and one operations director) to help improve line management structure and oversight.
- Managers had made some improvements to their governance system for their oversight of restraints and safeguarding adults' procedures. Staff had improved their recording of incidents. The provider had made some improvements to ensure staff received feedback from investigation of incidents.
- Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of stopping over-medication of people with a learning disability, autism or both (STOMP).
- Staff completed assessments of patients either on admission or soon after. Care plans were personalised. Positive behaviour support plans were present and supported by a comprehensive assessment.
- Staff were discreet, respectful, and responsive when caring for patients. Staff used appropriate communication methods to support patients to understand and manage their own care treatment or condition.
- Most staff felt respected, supported and valued. They were positive about the management changes since our April 2019 inspection.

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 	Cygnet Yew Trees is a 10-bed hospital for women aged 18 years and above who have a learning disability.

Summary of findings

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Inadequate

Cygnet Yew Trees

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

Summary of this inspection

Background to Cygnet Yew Trees

Cygnet Yew Trees is a 10-bed hospital for women aged 18 years and above who have a learning disability. The provider for this location had changed in May 2019 to Cygnet (OE) Limited. This location was registered with the Care Quality Commission on 27 November 2012 for the following regulated activities:

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

• Treatment of disease, disorder or injury.

The location has a registered manager. They plan to submit the relevant documentation to become a Controlled Drugs Accountable Officer.

The Care Quality Commission carried out a comprehensive inspection of this service on 30 April 2019 and identified a breach of regulation 12 (safe care and treatment) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to staff observation records, the provider's system to safeguard of patients and governance. The provider sent us their action plan to address this breach following this inspection.

The Commission carried out a focused inspection following information of concern and we found the provider had made some improvements, but we continued to find a breach of regulation 12 (safe care and treatment) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to staff observation of patients, incident reporting and investigation, notifications to external agencies and governance. We issued a section 29 warning notice with a date for compliance by 17 January 2020. We also issued a requirement notice. The provider sent us their action plan to address this breach following this inspection.

At this comprehensive inspection we found that they did not make the required improvements. We identified a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for regulations 12 (safe care and treatment),16 (receiving and acting on complaints), and 17 (good governance). We imposed conditions on the provider's registration at this location, under Section 28 of the Health and Social Care Act 2008. Since this inspection, the provider has sent the CQC information outlining how they will be reviewing and addressing a breach of Regulation 12, safe care and treatment and Regulation 17, good governance relating to the conditions.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, an inspection manager, an assistant inspector and a specialist advisor nurse.

Why we carried out this inspection

We carried out this inspection over three days and reviewed information sent to us by the provider post inspection.

This was an unannounced inspection.

We inspected this location to check on the provider's actions after the CQC had issued a section 29 warning notice for a breach of regulation 12 safe care and treatment. The CQC made a decision to also carry out a comprehensive mental health inspection, in accordance with our methodology.

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?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with three patients who were using the service;
- spoke with three carers of patients using the service;
- spoke with three managers including the registered manager, deputy manager and regional manager;
- spoke with 10 other staff members; including a doctor, nursing staff, occupational therapist, psychology staff, speech and language therapist and housekeeping;
- attended and observed a morning team meeting and a staff shift hand-over meeting;
- looked at seven care and treatment records of patients;
- carried out a specific check of the medication management; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with three of ten patients. All gave examples of how staff had given them support with their care and treatment such as with their physical health and medication. All patients said they regularly went out into the local community. Two patients said staff involved them in their care. Two patients said they had enough activities to do in the hospital and liked the food. However, one patient was less satisfied with the support and care given by staff. One patient told us they felt safe at the hospital but told us about an incident which was investigated.

We spoke with three carers. All gave examples of where staff had been caring and supportive of patients.

However, all three said that staff's communication with carers about changes in the hospital and changes to their relatives' care and treatment needed improving. Two carers gave examples of staff not handing over information from shift to shift. Two carers said there were times when there was not enough staff such as to support patients to go on community leave, there was more agency than permanent staff, who did not know patients' needs and staff were not always visible. Carers told us they knew how to make a complaint and one carer said they had received insufficient feedback from this. One carer said there were not enough activities to do in the hospital.

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

Our rating of this service stayed the same. We rated it as inadequate because:

- The provider did not make the required improvements that we told them were needed at previous inspections in April and October 2019. Staff were not keeping accurate observation records of patients and we found examples where staff were not observing patients in line with the provider's policy or The National Institute for Health and Care Excellence guidance: 'Violence and aggression: short-term management in mental health, health and community settings [NG10]'. This posed a risk staff would not observe patients who were at risk of harming themselves or others.
- At our April 2019 inspection we had identified a potential risk of the service not having enough female staff at the hospital to support patients. At this inspection from November 2019 to January 2020 only 40% of staff were female. This posed a risk there would be insufficient female staff to support patients, such as with personal care needs.

At this inspection we also found:

- Staff did not ensure relevant patients' care plans detailed how to keep patients who might experience a seizure safe in line with The National Institute for Health and Care Excellence 'Epilepsy in adults Quality standard [QS26]'.
- The provider did not ensure that staff had easy access to essential information. We received conflicting information from staff about where the up to date care plans and risks assessments were for patients, therefore not all staff on duty knew where to locate information.
- The environment did not provide sufficient space to meet the needs of current patients. The staffing levels required to undertake patient observations made the environment crowded. The majority of incidents of violence and aggression were from patients towards other patients and staff.

However:

- Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- Staff completed risk assessments for each patient on, using a recognised tool the Short-Term Assessment of Risk and Treatability (START), and reviewed this regularly.

Summary of this inspection

- Managers had made improvements to the safeguarding adults' procedures. Staff had improved their recording of incidents. The provider had made some improvements to ensure staff received feedback from investigation of incidents.
- Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of stopping over-medication of people with a learning disability, autism or both (STOMP).

Are services effective?

Good

Our rating of this service stayed the same. We rated it as good because:

- Staff completed assessments of patients either on admission or soon after. Care plans were personalised. Positive behaviour support plans were present and supported by a comprehensive assessment. Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes such as the 'Disability Distress Assessment Tool' and 'The Model of Human Occupation Screening Tool'. Staff developed health action plans and hospital passports. Patients were registered with a local GP.
- The provider employed a speech and language therapist to assess patients' needs and a therapy assistant helped support patients and staff.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Staff understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity for patients who might have impaired mental capacity.

Are services caring?

Requires improvement

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

- We spoke with three carers,who told us that not all staff communicated effectively about the changes in the hospital and changes to their relatives care and treatment needed improving.
- We checked seven patients care and treatment records and did not see that carers were involved in the development of care plans.

However:

Summary of this inspection

- Staff were discreet, respectful, and responsive when caring for patients. Staff used appropriate communication methods to support patients to understand and manage their own care treatment or condition.
- We spoke with three patients who gave examples of how staff had given them support with their care and treatment such as with their physical health and medication. We saw examples of how staff had involved patients in their care planning and risk assessments.

Are services responsive?

Requires improvement

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

- The provider did not make the required improvements that we told them were needed at previous inspections in April 2019 inspection. They did not fully demonstrate how they were meeting the accessible information standards to meet patients' needs which we had identified as an issue at our April 2019 inspection. There is a requirement of all providers of NHS care and publicly-funded adult social care to follow the Accessible Information Standard in full of 1 August 2016 onwards - in line with section 250 of the Health and Social Care Act 2012.

At this inspection we also found:

- Staff did not respond to complaints in line with the provider's policy. We checked a sample of four complaints, received since April 2019, and found three complaints did not have written acknowledgment, one did not have a response given and one was response was outside the provider's timeframe.
- The provider had eight of 10 patients with delayed discharges in the past year. The provider had given notice for five patients whose needs could no longer be met at this hospital. This included patients requiring a more intensive care environment, and those requiring bespoke community care packages. Staff spoke with us about the challenges of liaising with external community teams, commissioners and care providers to identify suitable placements and for arranging funding. The average length of stay at the hospital was three years. This is an increase since our April 2019 inspection and above the national average (554 days). Staff told us this had led to patients being in hospital longer than required. In some cases, this caused frustration for patients, which had led to challenging behaviour and incidents.

Summary of this inspection

- Staff did not have the full range of rooms to fully support treatment and care due to limited space. When incidents of patients' challenging behaviour occurred, this had a notable impact on the ward. For example, due to the noise, proximity and limited room/area access.

However:

- Each patient had their own bedroom, which they could personalise. Patients had a secure place to store personal possessions. Patients could make phone calls in private. The service had an outside space that patients could access easily.
- The provider monitored how much therapeutic activity patients had. They had a minimal standard of achieving 25 hours a week. Data available from 9 December 2019 to 19 January 2020 showed they achieved over 90% compliance with this. Staff supported patients with activities outside the service, such as education and helped patients to stay in contact with families and carers.

Are services well-led?

Inadequate

Our rating of this service stayed the same. We rated it as inadequate because:

- The provider did not ensure there was adequate leadership and oversight of this hospital to ensure actions for identified risks at our inspections in April and October 2019 were fully completed. This related mainly to staff observation of patients and governance systems.
- The provider did not ensure adequate governance structures, processes and systems of accountability for the performance of the service. We identified further risks with staff observation of patients, the provider's adherence to the workforce race equality standards, and the accessible information standards and ensuring sufficient gender mix of staff.
- The provider did not ensure that supervisors gave staff regular, constructive supervision of their work as per the provider's standard of six times in 12 months. This meant there was a risk staff did not get support for their role. Managers had not supported staff through regular, constructive appraisals of their work. The provider had achieved 69% compliance with staff appraisals.

Summary of this inspection

At this inspection we also found:

- We identified further risks with the provider's systems for assessing and monitoring of staff response to complaints, adherence to The National Institute for Health and Care Excellence guidance for care plans for patients at risk of epilepsy, staff access to records, involvement of carers.
- The provider did not have systems in place to ensure the effective sharing and implementation of policies such as physical health policy, epilepsy care pathway and their 'engagement and observation policy' to all medical and nursing staff.

However:

- Managers made some changes to the service and improvement for risks they had identified, for example safeguarding processes. They were developing better links with other services within Cygnet Healthcare to provide further support.
- The provider was bringing this and other local hospitals under one-line management 'healthcare' structure and one operations director, to help improve line management structure and oversight.
- Managers had regular opportunities to meet. Most staff felt respected, supported and valued. They were positive about the management changes since our April 2019 inspection. Managers had an awareness of the need to ensure closed cultures did not develop on the ward and hospital. The team culture was developing.

Detailed findings from this inspection

Mental Health Act responsibilities

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

All patients were detained under the MHA when we visited. Staff received and kept up-to-date with training on the MHA and the MHA Code of Practice. Information from the provider reported 95% training compliance. However, agency staff training records did not always show if staff had received comparable training.

Staff had access to support and advice on implementing the MHA and its Code of Practice.

Staff knew who their MHA administrators were and when to ask them for support. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the MHA Code of Practice.

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

Staff explained to each patient their rights under the MHA in a way that they could understand and repeated and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff had not gained the correct legal authority to administer medication (as and when required) to one patient. However, after we had brought this to their attention, staff completed paperwork to administer urgent medication under section 62 of the MHA. We saw examples, where staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

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

Managers and staff made sure the service applied the MHA correctly by completing audits and discussing the findings.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received and kept up-to-date with training in the Mental Capacity Act (MCA). Information from the provider reported 91% training compliance. However, agency staff training records did not always show if staff had received comparable training.

Staff knew where to get advice on the MCA and Deprivation of Liberty Safeguards.

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

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

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

No patients were subject to a Deprivation of Liberty Safeguards order when we visited.

Inadequate

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

The environment did not provide sufficient space to meet the needs of current patients. The staffing levels required to undertake patient observations made the environment crowded.

The ward layout did not allow staff to observe all parts of the ward. There was closed circuit television which helped mitigate some of the risks of blind spots. However, there were still areas of the ward not covered by closed circuit television. Staff maintained enhanced level observations for patients who posed a risk to themselves or others. Senior staff had arranged for a contractor to install extra cameras to reduce the risk of blind spots at the end of January 2020.

Staff completed regular risk assessments of the care environment. This detailed all identifiable risks and actions staff should take to mitigate such risks. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. A health and safety audit in January 2020 identified a broken fire door in the lounge which the provider took action to address.

The provider only admitted female patients, therefore they were compliant with the Department of Health guidance on eliminating mixed sex accommodation. There was no seclusion room.

Staff had access to alarms and were able to call for assistance when necessary. The provider used a pinpoint alarm system and there were display units throughout the hospital to identify where the alarm had been activated. Patients did not have access to an alarm or nurse call system.

Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including handwashing.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Safe staffing

Information from the provider for January 2020, showed the provider's staffing establishment was 55.8 whole time equivalent (wte) staff and they had 36.4 wte employed staff. The provider had 35% staffing vacancies. Four of the nurse posts were vacant and the provider had covered these using regular agency nurses to provide continuity. There were 11 support worker vacancies (decreased from 14 at our April 2019 comprehensive inspection). Other vacancies were for non-nursing staff.

We had identified in our April 2019 inspection that the provider should ensure there was sufficient gender mix of staff available to meet patients' needs. However, we found there was still a risk of insufficient female staff to support patients, such as with personal care needs. Whilst managers calculated and reviewed the number and grade of nurses and support workers for each shift only 40% (in the last three months) were female. The provider had ensured a mix of skilled staff, with five learning disability and ten mental health nurses on duty in the same timeframe.

The hospital manager could adjust staffing levels according to the needs of the patients. They had increased the number of qualified nurses on each shift due to the high acuity of patients.

The hospital regularly used bank (as and when staff employed by the provider) or agency staff to cover shortfalls such as to cover enhanced continuous observation of patients. Information from the provider for April to November 2019 showed 5,662 agency hours used and 50% of this usage was for nurses. Managers requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The service had enough staff on each shift to carry out any physical interventions. However, two of three carers we spoke with said there were times when there was not enough staff to support patients to go on community leave; there was more agency than permanent staff, who did not know patients' needs and staff were not always visible.

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Managers could call locums when they needed additional medical cover.

Information from the provider for the previous 12 months, showed they had employed 11 new staff and 10 staff had left. Their staffing data showed a staffing turnover of 42% (an increase from 27% at our April 2019 comprehensive inspection). The hospital's staff sickness rate was 2%. This was lower than the average for NHS staff in England (4.2%, July to September 2019, source: NHS digital). Managers supported staff who needed time off for ill health.

We found issues with mandatory training compliance. Records showed seven of 43 staff (16%) were below 75% compliance. This included five staff who started employment after November 2019 with 0% compliance. The manager stated this was an error and staff had received an induction, however no evidence to support this was provided. Staff were 97% compliant with infection control, food safety, fire safety and 80% complaint with intermediate life support and 93% compliant with basic life support.

Assessing and managing risk to patients and staff

We previously identified risks at our April and October 2019 inspections that staff were not keeping accurate observation records of patients and there were occasions where staff were not observing patients according to the provider's policy. We found at this inspection staff did not fully adhere to the provider's policy or The National Institute for Health and Care Excellence guidance: 'Violence and aggression: short-term management in mental health, health and community settings [NG10]'.

We checked a sample of records from December 2019 and January 2020 for the observation of three patients. Two patients were on enhanced observations to reduce risks to themselves or others. Staff did not accurately complete observation records. In four examples, staff did not record when they had observed patients. Eleven observation records did not detail the level of patient observation required. Eight examples had not been verified for accuracy by the nurse in charge. We found 11 examples of staff being on continuous observations for more than two hours. This poses a risk that staff would become tired and unable to adequately observe patients who were at risk of harming themselves or others. One patient's engagement and observation plan did not clearly identify when they required three staff to observe them instead of two. Another patient's plan identified for two staff to observe them at all times. However, staff observation records showed only one staff was observing them at night. One patient's care plan identified they should have two staff checks by staff per night. This plan was also not in line with the registered provider's 'engagement and observation policy' which required a minimum of hourly checks for all patients.

Observation records did not reflect the level of detail required by the service. In team meeting minutes from 25 November 2019, managers requested staff include greater detail regarding the observation and activity of patients. They provided an appropriate template for this. Despite this, most records held minimal information to indicate staff made thorough checks to ensure the patient's safety. For example, at night, where staff had documented 'appears asleep'.

We checked three care plans for patients who had been identified as having a risk of epileptic seizure. These did not contain adequate information to effectively manage this risk. Staff did not ensure these care plans adhered to the provider's 'epilepsy care pathway' or The National Institute for Health and Care Excellence 'Epilepsy in adults Quality standard [QS26]'. This posed a risk that staff would not know how to prevent and manage a seizure. However, the

provider had ensured that staff had information on how to administer emergency medication to patients if required and had additional staff training planned for February 2020.

Provider information from April 2019 to January 2020 showed 391 occasions of staff restraint of patients. This included four occasions when staff used prone (face down) restraint with patients. The 2015 Mental Health Act Code of Practice states that 'unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position'. There were no reported incidences of seclusion. Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation. There were 29 incidents of use from April 2019 to January 2020 with 23 of these in December 2019. We found a reported incident where staff had restrained a patient and given them rapid tranquilisation and it was unclear why this was required. We raised this with the hospital manager who informed us they were investigating this incident further to establish what had happened and if the staff's response was justifiable.

We checked staff assessments for three patients and they had gaps in information. For example, two did not fully capture the patient's risk history. This posed a risk that staff would not know how to effectively support patients at the hospital. We noted staff had used the previous provider's documentation and the current provider had different documentation.

Managers had made some improvements to their governance system for monitoring restraints to identify if this posed risk for the hospital or patients. Information from the provider on site, showed staff were 91% compliant with restraint training and 100% compliant with breakaway training. Psychology staff had developed positive behavioural support plans for staff to follow to reduce the risk of restraint and had 'grab sheets' to make this information more accessible for staff who may not know the patient. There was not an identified lead for restraint at the hospital, but staff could request support from the provider when needed.

Staff completed risk assessments for each patient on admission, using a recognised tool the Short-Term Assessment of Risk and Treatability (START), and reviewed this regularly. There was one error detected on a patient's daily risk assessment which stated they could not have community leave whereas other records showed they recently had some leave. Staff did not update one patient's risk management plan for community leave in hospital transport, to give sufficient information for escorting staff to know where they should position themselves to reduce the risk of an incident.

Staff followed policies and procedures when they needed to search patients or their bedrooms. Staff applied blanket restrictions on patients' freedom only when justified, such as restricting patients' access to the kitchen to make hot drinks, if they posed a risk of harm to themselves or others.

Safeguarding

The provider had a safeguarding policy in place for staff reference. Staff received training on how to recognise and report abuse. Information from the provider showed 90% staff compliance with levels one to three safeguarding training and 93% compliance for safeguarding assessment training. The consultant psychiatrist had completed level four specialist training. We checked six agency staff records and found the provider had improved their checks to ensure, for example, that staff had completed safeguarding vulnerable adults training and had enhanced disclosure and barring service' (DBS) checks before working at the hospital.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The deputy manager was making changes to their systems for reporting, investigating and reviewing safeguarding concerns. They had made improvements for the hospital's liaison with the local safeguarding team. Information from the provider in January 2020 showed 15 incidents recorded with 14 being investigated. Staff developed protection plans to detail the care and treatment they should give to safeguard patients following safeguarding incidents.

Staff gave examples of how to protect patients from harassment and discrimination.

Staff followed procedures to keep children visiting the ward safe.

Staff access to essential information

The provider did not ensure that staff had easy access to essential information. When we visited on 13 January 2020 the provider's telephone line was not working. This affected staff access to the electronic patient record and shared drive which also held governance information. We received

conflicting information from staff about where the up to date care plans, discharge plans and risk assessments were for patients, therefore not all staff on duty knew where to locate information.

We found at follow up visits, staff held information about patients in various places, for example, in the electronic patient record and in large paper files. We were not assured staff had easy access to all patient information to care for patients. For example, risk assessments and care plans were on both electronic and paper records, but discharge plans were in a paper folder. Records were stored securely. The provider ensured regular agency staff had access to electronic patient records.

Medicines management
Staff followed systems and processes when prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

The service worked towards achieving the aims of stopping over-medication of people with a learning disability, autism or both (STOMP).

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance.

Track record on safety
The majority of incidents reported, related to violence and aggression by patients towards other patients or staff.

The provider had made two notifiable reports to the Health and Safety Executive, relating to 'Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013', regarding patient assaults on staff and injuries.

Reporting incidents and learning from when things go wrong
Staff had improved their recording of incidents. We tracked a sample of 10 incidents staff had documented in records and found evidence that staff reported all but one of them, which we raised with the manager for further investigation.

Staff and patients had opportunities for debriefs after incidents. The consultant psychiatrist and registered manager had completed root cause analysis training to assist when investigating incidents. The deputy manager was awaiting training for this.

The provider had made some improvements to ensure staff received feedback from investigation of incidents, both internal and external to the service. Staff discussed incidents in their morning meeting and documented them in shift handover records. Managers had developed a 'lessons learnt' folder to help staff access information. However, systems were still embedding. There was some evidence that changes had been made as a result of feedback. For example, following learning from an incident staff used body maps to identify patient injuries such as from self harm. Managers had changed the plan for staff escorting a patient.

Are wards for people with learning disabilities or autism effective?
(for example, treatment is effective)

Good

Assessment of needs and planning of care
We reviewed seven patients records.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward and had an up-to-date hospital passport.

Staff regularly reviewed and updated most care plans and positive behaviour support plans when patients' needs changed. Care plans were personalised.

Positive behaviour support plans were present and supported by a comprehensive assessment.

Best practice in treatment and care
Staff provided a range of care and treatment suitable for the patients in the service.

Staff understood patients' positive behavioural support plans and provided the identified care and support.

We found examples, where staff had supported patients to access physical health care, including specialists as required. Staff developed health action plans and hospital passports. Patients were registered with a local GP.

Inadequate

Wards for people with learning disabilities or autism

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example 'The Model of Human Occupation Screening Tool' Not all patients had verbal communication skills. The provider employed a speech and language therapist to assess patients' needs and additionally a therapy assistant helped support patients and staff. Staff developed communication passports for patients to help with communication. Staff used Makaton signs and symbols with patients as relevant.

Staff used the 'Disability Distress Assessment Tool'. This helped staff to assess patients with severe communication difficulties and distress. Additionally the occupational therapist provided sensory assessments.

Skilled staff to deliver care

The team included or had access to a range of professionals required to meet the needs of patients. This included doctors, nurses, support workers, a clinical psychologist and therapy staff. The service employed an occupational therapist following our April 2019 inspection. We checked a sample of three staff files and the interviewer did not fully complete their interview assessment to evidence the staff member met the requirements for employment.

Managers gave each new permanent member of staff an induction to the service before they started work and managers arranged for new staff have a 'buddy' to give them support.

Managers made sure staff attended regular team meetings or made information available to those who could not attend.

Managers identified staff training needs gave them the time and opportunity to develop their skills and knowledge. Managers recognised poor performance, could identify the reasons and dealt with these appropriately. However, we have identified issues with the provider's oversight of staff supervision and appraisal compliance, which we have reported on in the well led domain.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. However, the provider combined care and treatment reviews and care programme approach meetings. This conflicted with NHS guidance which requires separation due to the nature of discussions. We were told this took place due to requests from commissioners.

New managers had made improvements to ensure staff shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with teams internal and external to the organisation.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

Staff were discreet, respectful, and responsive when caring for patients.

We spoke with three of ten patients (30%). All gave examples of how staff had given them support with their care and treatment such as with their physical health and medication. However, one patient was less satisfied with the support and care given by staff. We spoke with three carers. All gave examples of where staff had been caring and supportive of patients.Staff used appropriate communication methods to support patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

We saw examples of how staff had involved patients in their care planning and risk assessments. Two of three patients said staff involved them in their care.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. For example, staff

used Makaton signs, and had photograph cards also on key rings to help patients know what was happening that day and let staff know what they wanted. Staff also used 'talking mats' to communicate with patients.

Staff introduced patients to the ward and the services as part of their admission.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff made sure patients could access advocacy services.

Three carers told us staff's communication with carers about changes in the hospital and changes to their relatives' care and treatment needed improving. Two carers gave examples of staff not handing over information from shift to shift. We checked seven patients' care and treatment records and did not see that carers were involved in their development. However, one carer told us that staff communication had improved after they had complained. Staff told us carers could attend care review meetings (with the patient's consent) and give their views on the patient's care and treatment.

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

Requires improvement

Access and discharge

The hospital had 100% occupancy when we visited. Some patients were placed at the hospital away from their local area. The average length of stay at the hospital was three years. This is an increase since our April 2019 inspection and above the national average (554 days).

The provider had eight of 10 patients with delayed discharges in the past year. The provider had given notice for five patients whose needs could no longer be met at this hospital. This included patients requiring a more intensive care environment, and those requiring bespoke community care packages. Staff spoke with us about the challenges of liaising with external community teams, commissioners and care providers to identify suitable placements and for arranging funding. Staff told us this had led to patients being in hospital longer than required. In some cases this caused frustration for patients, which had led to challenging behaviour and incidents.

Stakeholder feedback indicated the provider had not always offered sufficient rehabilitative care to prepare patients for community living. This had impacted on their length of stay in the hospital.

The facilities promote recovery, comfort, dignity and confidentiality

Staff did not have the full range of rooms to support treatment and care due to limited space. When incidents of patients' challenging behaviour occurred, this had a notable impact on the ward. For example, increased noise levels, the proximity of the incident to other patients and access to quiet spaces. If patients wanted a quiet area, they needed to go to their rooms unless another communal room was not in use. The provider had plans to redevelop the lounge area and introduce a sensory room. The hospital had a room which could be booked for patients to meet with visitors in private.

The provider monitored how much therapeutic activity patients had. They had a minimum standard of 25 hours a week. Data available from 9 December 2019 to 19 January 2020 showed they achieved over 90% compliance with this (data was missing for the week of 16 December 2019). Staff told us that more activities took place since our April 2019 inspection. Two of three patients said they had enough activities to do in the hospital. Patients' had individual activity plans, for example activities of daily living, breakfast club, mindfulness, flower arranging and 'tickle squeeze' (patient named activity for massage). One of three carers we spoke with said there were not enough activities to do in the hospital.

Each patient had their own bedroom, which they could personalise. Patients had a secure place to store personal possessions. Patients could make phone calls in private. The service had an outside space that patients could access easily.

Due to the ward layout and risks identified for patients, patients required staff assistance to make their own hot drinks and snacks. Two of three patients we spoke with said they liked the food.

Inadequate

Wards for people with learning disabilities or autism

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as education and helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service supported and made adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The provider had information and correspondence in formats that patients could read and understand, for example in easy read or large print. They had a good range of visual information displayed on walls and doors for patients including activity timetables, Makaton signs, 'now and next boards' and photo cards. Managers ensured that staff and patients had easy access to interpreters and/or signers. However, the provider did not clearly identify how they were meeting the accessible information standards to meet patients' needs which we had identified as an issue at our April 2019 inspection. There is a requirement of all providers of NHS care and publicly-funded adult social care to follow the Accessible Information Standard in full as of 1 August 2016 - in line with section 250 of the Health and Social Care Act 2012.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The provider needed to improve how staff responded to patients and others' complaints and ensure that staff followed the provider's policy. The provider had received four complaints from August 2019 to January 2020. We checked records for these and found gaps in how staff responded to them. For example, three complaints did not have written acknowledgment, one did not have a response given and one response was outside the provider's timeframe. The provider had received three compliments in the same time period.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

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

Inadequate

Leadership

The provider did not ensure adequate leadership and oversight of this hospital to ensure actions for identified risks at our inspections in April and October 2019 were fully completed. Whilst the provider had employed a new hospital manager, deputy manager and regional manager they had not been able to complete all actions. However, we found they were making some changes to the service and improving in certain areas, such as safeguarding adults. They were developing better links with other services within Cygnet Healthcare to provide further support.

Staff reported less visibility of senior leaders. Managers told us the provider was making additional changes to bring their local hospitals under one line hospital management healthcare structure. Leadership development opportunities were available for staff. Managers told us that there were opportunities for development of their skills.

Vision and strategy

The provider had given staff information about their vision and values. The provider had identified the following values 'integrity, trust, empower, respect and care'.

Culture

Most staff felt respected, supported and valued. They were positive about the management changes since our April 2019 inspection. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear. Managers dealt with poor performance when needed. The provider held 'employee of the month' awards and had arranged Christmas gifts for staff.

Managers had an awareness of the need to ensure closed cultures did not develop on the ward and hospital. The team culture was developing.

Inadequate

Wards for people with learning disabilities or autism

The provider had reviewed information given by staff but did not have a robust or current workforce race equality standards action plan to address any issues identified. The provider gave us information about their analysis of data and feedback from their staff survey relating to workforce race equality standards for 2018, but their plan was not specific, measurable, attainable, relevant, and time-based. This posed a risk that staff actions would be ineffective for issues identified.

Governance

The provider did not ensure they had robust governance structures in place to assess and monitor how the hospital was performing. They did not ensure that the actions from previous inspections were completed and that their action plans were effective. For example, there were still risks for staff observations of patients, supervision and appraisal of staff, adherence to accessible information standards requirements and consideration of gender mix of staff in the service. We identified further risks with the provider's systems for assessing staff appraisal, response to complaints, and how they were addressing actions from their analysis of staff survey results regarding the workforce race equality standards. There were failures in audit processes. The provider did not fully ensure audits and action plans were completed for health and safety, rapid tranquilisation and infection control.

The provider did not have systems in place to ensure the effective sharing and implementation of policies such as physical health policy, epilepsy care pathway and their 'engagement and observation policy' to all medical and nursing staff.

Managers had regular opportunities to meet. The hospital manager carried out a daily quality assurance 'walk around' the hospital but was not always recording their assessment checks.

Managers did not support staff through regular, constructive supervision of their work as per the provider's standard of six times in 12 months. This meant there was a risk staff did not get support for their role. The provider reported 91% compliance. However, we were unable to match this data with evidence in staff records. We had identified this as a risk at our April 2019 inspection.

Managers had not supported staff through regular, constructive appraisals of their work. The provider reported 94% compliance. However, on recalculation of the information provided the actual compliance figure was 69%.

Management of risk, issues and performance

The provider did not ensure adequate governance systems were in place to monitor and reduce risks to patient safety at this location identified from our 2019 inspections. Hospital managers, stakeholders and the CQC had identified concerns relating to the number of incidents at the service due to the number of patients with complex needs and challenging behaviour. The provider had recorded these concerns on their local risk register, together with risks related to increased use of agency staff and inadequate closed circuit television coverage.

The provider had taken some action to reduce risks through giving notice to commissioners that they were discharging five patients and that commissioners would need to identify appropriate placements (most of these patients no longer required hospital admission). Additionally whilst the hospital was full when we visited the provider had voluntarily suspended patients' admissions so they could make changes to the patient mix.

Information management

The provider did not ensure they collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. For example, staff supervision and appraisal data was not accurate. The information systems inaccurately gave a higher level of staff compliance than we found through checking staff records.

Engagement

The provider had systems to engage with patients, staff, and stakeholder organisations to gain feedback on its services.

Whilst we had feedback from three carers about staff communication issues, the provider had arranged quarterly carers' events to encourage feedback on their service and help with communicating changes.

Inadequate

Wards for people with learning disabilities or autism

Learning, continuous improvement and innovation

The new management team was still developing but staff told us they were encouraged to consider opportunities for improvements and innovation. The hospital currently did not participate in accreditation schemes relevant to the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff observe patients appropriately to ensure they are safe.
- The provider must ensure staff follow good practice guidance in the care of patients that may experience epileptic seizures.

This is a breach of Regulation 12 (1)(2)(a)(b),safe care and treatment, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider must ensure effective leadership, oversight, governance and resources at this hospital to reduce identified risks.
- The provider must ensure staff know where to access patients' current care and treatment records.
- The provider must ensure appropriate gender mix of nursing staff on duty to support patients.
- The provider must review how they are meeting the accessible information standards to meet patients' needs, in line with section 250 the Health and Social Care Act 2012.
- The provider must review how they are meeting for the Workforce Race Equality Standard.
- The provider must review their appraisal and supervision assessment and monitoring systems.

Outstanding practice and areas for improvement

This is a breach of Regulation 17 (1)(2)(a)(b)(c) good governance, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider must ensure staff follow the provider's complaints policy.

This is a breach of Regulation 16(1)(2) Receiving and acting on complaints, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action the provider SHOULD take to improve

- The provider should review their hospital admission assessment processes.
- The provider should review their discharge planning processes with commissioners.
- The provider should ensure all their audits of this hospital are fully completed with identified action plans.
- The provider should ensure managers have access to accurate staff training data.
- The provider should ensure regular staff review of mental health act documentation to ensure staff administer medicines with the correct legal authorisation.
- The provider should review their systems for communication and involvement with carers of patients.
- The provider should review their policy for not having alarms in patient bedrooms for patients to use to summon help in an emergency.

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 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

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

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

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