

# Cygnet Learning Disabilities Midlands Limited

## Cygnet Views

### Inspection report

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Date of inspection visit: 8, 9, 14 June 2021  
Date of publication: 02/09/2021

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

### Ratings

| Overall rating for this location           |  | Inadequate           |  |
|--------------------------------------------|--|----------------------|---------------------------------------------------------------------------------------|
| Are services safe?                         |  | Inadequate           |  |
| Are services effective?                    |  | Inadequate           |  |
| Are services caring?                       |  | Requires Improvement |  |
| Are services responsive to people's needs? |  | Good                 |  |
| Are services well-led?                     |  | Inadequate           |  |

# Summary of findings

## Overall summary

The Chief Inspector of Hospitals, Ted Baker, is placing Cygnet Views 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.

Cygnet Views is an independent hospital situated in Matlock, Derbyshire providing care for up to ten women with learning disabilities, behaviour that could challenge and complex mental health needs. Our rating of this location went down. We rated it as inadequate because:

Patients didn't always receive safe care. Managers did not always follow good practice with respect to safeguarding and the use of restrictive practices.

Opportunities to prevent or minimise harm were missed. Local risk assessments failed to identify significant ligature points across the hospital.

Staff didn't always have the skills required to support this patient group. The provider only made specific training available for some staff which meant not all patient needs were understood and addressed.

Patients were not always supported with their physical health or encouraged to live healthy lives by staff.

Staff did not always understand how the Mental Capacity Act 2005 related to the patients they supported.

The hospital was not always well led, and the governance processes did not ensure that hospital procedures ran smoothly.

However:

Staff followed infection control policy, including handwashing. This was an improvement from our previous inspection when we issued a warning notice about this and told the provider they must improve staff infection prevention and control practices to keep people safe during the COVID-19 pandemic.

Staff developed recovery-oriented care plans informed by a comprehensive assessment. They worked with patients and with families and carers to develop individual care and support plans and updated them as needed. Care plans reflected the assessed needs and were personalised and strengths based. However, they were not consistent as we found that care plans around patients' physical health needs were not collaborative, holistic and updated to the same standard.

# Summary of findings

The hospital environment was clean and tidy. Staff assessed and mostly managed risk well and managed medicines safely.

The multidisciplinary team were able to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging. However, they communicated this to staff in an inconsistent way.

The hospital team included or had access to the full range of specialists required to meet the needs of patients in the hospital. The hospital staff worked well together as a multidisciplinary team and with those outside the hospital who would have a role in providing aftercare. Staff were able to access supervision and appraisal.

Staff treated patients with compassion and kindness. However, they did not always respect their privacy and dignity. They involved patients and families and carers in care decisions.

Staff planned and managed discharge well and liaised with hospitals that would provide aftercare. Discharges were delayed only due to clinical reasons.

# Summary of findings

## Our judgements about each of the main services

### Service

**Wards for people with learning disabilities or autism**

### Rating

Inadequate



### Summary of each main service

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# Summary of findings

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# Summary of this inspection

## Background to Cygnet Views

Cygnet Views is an independent hospital situated in Matlock, Derbyshire. The hospital provides care and support for up to ten women with learning disabilities, behaviour that could challenge and complex mental health needs. At the time of our inspection there were eight patients. There was a registered manager who is a person who had registered with the Care Quality Commission to manage the hospital.

The registered manager has a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations.

Cygnet Views are registered with the CQC for:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury

We last inspected Cygnet Views in November 2020 this was a focused inspection looking at Safe and Well led. We had inspected due to concerns raised about the hospital.

We rated Cygnet Views requires improvement overall and rated Safe and Well led domains as requires improvement.

Following that inspection, we issued a warning notice. We told the provider they must improve staff infection prevention and control practices to keep people safe during the COVID-19 pandemic.

During this inspection we found that the provider had acted on the warning notice and staff were aware of and carried out infection prevention and control practices.

### **What people who use the hospital say**

People told us they felt safe although they do get affected when there are incidents at the hospital.

People told us that the staff were caring, and they could talk to them.

People told us that there were activities for them to do during the day, evening and at weekends. However, these could be cancelled if there was not enough staff to facilitate the sessions.

People told us that the food was healthy and good, and they could access plenty of hot and cold drinks when they wanted to.

People told us that they had access to the large garden when they wanted.

People told us that they can access their section 17 leave. However, this can be cancelled when there is not enough staff to facilitate this.

# Summary of this inspection

Carers told us that they feel that their loved ones are safe. However, they are aware that there are lots of incidents that happen there, and this can affect the person they care for.

Carers told us that there is good communication between the hospital and them and have been able to contact their loved ones during the pandemic through phone and video calls.

Carers told us that even though the length of stay for some of their loved ones has been long they feel that they are able to learn skills to help them when they are discharged.

## How we carried out this inspection

We carried out this unannounced inspection of Cygnet Views as part of our continual checks on the safety and quality of health care hospitals.

This was a comprehensive inspection looking at all five domains.

To carry out this inspection two inspectors were on site on 8, 9 June 2021 and on 14 June 2021.

An expert by experience made phone calls remotely to carers on 10 June 2021.

We spoke to ten members of staff.

We spoke to four patients and four carers.

We attended a multidisciplinary daily meeting whilst on site.

We looked at eight patient care plans and seven patient physical health plans.

We looked at the environment of the hospital.

We looked at a range of policies, procedures and other documents relating to the running of the hospital.

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

## Areas for improvement

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

### **Action the hospital **MUST** take to improve:**

We told the hospital that it must take action to bring the hospital into line with five legal requirements.

The provider must ensure all areas of the hospital are assessed for ligature risks and act to reduce risks to protect patients from harm. (Regulations 12(2)(a))

# Summary of this inspection

The provider must ensure that physical health care risks are being monitored and effectively mitigated. (Regulation 12 (a)(b))

The provider must ensure that all staff receive training to maintain necessary skills to meet the needs of the people they care for and support. (Regulation 18(2)(a))

The provider must ensure that all patients receive appropriate treatment which meets their needs and where a person lacks the mental capacity to make specific decisions, their best interests should be considered and acted on. (Regulation 9(3)(a)(5))

The provider must ensure they enable and support patients to understand the care or treatment choices available to them and to discuss with a competent health professional the balance of risks and benefits involved in any particular course of treatment. (Regulation 9 (3))

The provider must ensure patient's records are fit for purpose. (Regulation 17(2)(c))

The provider must ensure that the quality of care is monitored and improved through regular audit, reviewed and action planned as part of their clinical governance systems. (Regulation 17 (2) (a))

# Our findings

## Overview of ratings

Our ratings for this location are:

|                                                       | Safe       | Effective  | Caring               | Responsive | Well-led   | Overall    |
|-------------------------------------------------------|------------|------------|----------------------|------------|------------|------------|
| Wards for people with learning disabilities or autism | Inadequate | Inadequate | Requires Improvement | Good       | Inadequate | Inadequate |
| Overall                                               | Inadequate | Inadequate | Requires Improvement | Good       | Inadequate | Inadequate |

# Wards for people with learning disabilities or autism

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

## Are Wards for people with learning disabilities or autism safe?

Inadequate 

### Safe and clean care environments

The hospital was not always safe and fit for purpose. However, it was clean and well maintained.

### Safety of the hospital layout

Staff could observe patients in all parts of the hospital.

Staff had easy access to alarms and patients had easy access to nurse call systems. We found there were alarm points in patients' bedrooms, bathrooms areas and in communal areas. Patients' knew the whereabouts and how to use them.

Safety systems and processes were not fit for purpose. We found that staff did know all the potential ligature anchor points in the hospital identified in the local risk assessment. However, we found the local ligature risk assessment inaccurate as it did not include some potential ligature points we identified in bedrooms. The document we reviewed only made mention of these risks in one bedroom although they were present in all ten. The provider later told us that this was an oversight in writing up the report from the assessment document in which these risk had been identified in all rooms. This was despite similar ligature risks being identified and actioned for improvement as part of Cygnet's national review of ligature risks inside their hospitals.

### Maintenance, cleanliness and infection control

Hospital areas were clean, well maintained and well-furnished. Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing. We observed staff utilised the hand sanitisers found in each area of the hospital. Staff wore masks correctly and had temperature checks at the start of each shift. This was an improvement from our previous inspection when we issued a warning notice about this and told the provider they must improve staff infection prevention and control practices to keep people safe during the COVID-19 pandemic.

### Clinic room and equipment

# Wards for people with learning disabilities or autism

Clinic rooms were fully equipped and the accessible resuscitation equipment and emergency drugs that were checked regularly.

Staff checked, maintained, and cleaned equipment. We found the clinic room to be tidy and well organised.

## Safe staffing

The hospital had enough nursing and medical staff, these staff were a mix of permanent and bank staff due to vacancies, they knew the patients and received basic training to keep people safe from avoidable harm.

## Nursing staff

The hospital had vacancies. Managers were trying to recruit one registered nurse and seven support workers. The hospital had a high turnover rate of care staff becoming bank workers to achieve flexibility in working hours. The hospital was using regular bank nurses and bank carers to ensure continuity of care whilst recruiting. These were sourced from the regional Cygnet bank staff pool who were familiar to the needs of the patients in the hospital.

Managers accurately calculated and reviewed the number of nurses and care staff for each shift. The manager could adjust staffing levels according to the needs of the patients. However, the three support workers we spoke to told us they felt there were not enough staff on each shift to carry out any physical interventions safely. The three patients we spoke with told us they have had their escorted leave or activities cancelled due to the hospital being short staffed due to staff being involved in incidents in the hospital.

## Medical staff

The hospital had enough daytime and night-time medical cover and a doctor was available to go to the hospital quickly in an emergency. We found during the week there was either the responsible doctor or the speciality doctor in attendance at the hospital. An on-call system was in place for when either doctor was not present and for weekends.

## Mandatory training

Overall mandatory training rates were high (recorded at 87%), although the provision of training for staff to support patients in some of the problems they faced was confined to only a small proportion of the staff group. All staff had training in working with people with autism, but only three out of 16 had completed a module on personality disorders and six out of 18 had been allocated the available training on physical healthcare awareness, dysphagia awareness, communication awareness and an introduction to learning disabilities.

The Royal College of Psychiatrists quality network inpatient learning disabilities standards include training in physical health awareness and recognising and communicating with patients with cognitive impairment, communication difficulties or learning disabilities as best practice to support the person-centred care. The lack of training for most staff in areas such as dysphagia awareness, despite two patients having a significant risk of choking, had an impact on the quality of care offered.

# Wards for people with learning disabilities or autism

This meant staff did not have the knowledge and skills to deliver good quality care to the patient group. Managers did not monitor mandatory training in a comprehensive way so they could be alerted when staff needed to update their training. Managers told us they use a training system called 'Achieve'. However, during the inspection they were not able to give us an accurate interpretation of training figures. Although, staff that we spoke with told us that they felt up to date with their training.

## Assessing and managing risk to patients and staff

Staff had the training to implement positive behaviour support plans, however the police regularly attended the site to provide staff and patients with support in de-escalating incidents. Two members of staff told us this was because the team lacked confidence in their ability to manage the immediate threat of violence.

## Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a 'daily risk assessment' tool which was reviewed each morning during the multidisciplinary meeting.

## Management of patient risk

Staff we spoke with said they were trained in how to use de-escalation techniques. However, two told us they were anxious as a team about using restraint. As a result, police were being regularly called to respond to incidents at the hospital by both staff and patients. We found that in the last three months the police have been contacted 11 times, eight times by patients and three times by staff. Two of those incidents resulted in police being assaulted by the patients.

Police had contacted the CQC with their concerns in November 2020 about the safety and management of patients in this hospital. Liaison meetings were set up to monitor police involvement at the hospital and were ongoing. In June 2021 the police contacted the CQC again to restate their concerns about the amount of calls for service from this unit. They recognised there had been periods where calls for service have decreased, but that they had appeared to be on the rise again.

The staff we spoke with told us they were not aware how to search patients and we were told of a recent incident where a patient following un-escorted leave had brought back an item which the patient could use to self-harm according to the patients care plan.

## Use of restrictive interventions

We found that in the three months between February to April 2021 there was a total of 192 incidents of actual violence and aggression shown by patients. Furthermore, 36 of those incidents resulted in the use of restraint in which seven of these restraints lasted over 20 minutes. There were no prone restraints recorded.

In the hospitals clinical governance reports for the three months February to April 2021 there is no mention of the police involvement in episodes of restraint on the hospital site or a plan to address the root causes of the failure to effectively manage behaviours that challenge with the hospital's own resources.

# Wards for people with learning disabilities or autism

We found in the past three months rapid tranquilisation was used twice. Staff followed NICE guidance when using rapid tranquilisation with post rapid tranquilisation physical health checks completed in both cases.

## Safeguarding

Staff understood how to protect patients from abuse and the hospital worked well with other agencies to do so.

Staff said they received training on how to recognise and report abuse, appropriate for their role. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they did not get feedback from managers on concerns raised.

The local police had raised concerns in November 2020 with the CQC regarding the number of calls from the hospital. Police were and remain concerned that the patients were not being adequately safeguarded and protected from harm. The local safeguarding authority had become involved in initially monthly and then reducing to bimonthly meetings to review police involvement at the unit.

## Staff access to essential information

Staff had access to clinical information through a combination of electronic and paper-based records. However, staff did not follow best practice in maintaining high quality clinical records. We found contradictions and omissions between the information recorded in the two sets of records.

The information needed to plan and deliver effective care, treatment and support was not up to date with correct information. Paper notes contained information that was contradictory to information found in the electronic ones. We found two patients' electronic notes with inconsistent information which would result in staff understanding incorrect information about the patients. However, patient notes were comprehensive and were stored securely.

Information about peoples care and treatment was not appropriately shared between staff. We found there was a lack of consistency with information sharing, it was highlighted as an issue in the monthly clinical governance meetings, but actions from this have not been completed.

## Medicines management

The hospital used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health. They knew about and worked to the hospital achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. The hospital worked to achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both). We found that on each patient's care plan that these reviews were completed, and clear direction was given from the speciality doctor on what medications each patient was on. STOMP was clearly discussed in patients care plans.

## Reporting incidents and learning from when things go wrong

# Wards for people with learning disabilities or autism

The hospital did not manage patient safety incidents well. Police have had to attend to incidents at the hospital and take over the management of them from staff. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the team and the wider hospital. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them.

Staff received debriefs in line with the provider policy of debriefing events with a severity rating of moderate or above.

Managers investigated incidents. Staff met to discuss the feedback and look at improvements to patient care in the multidisciplinary morning meetings.

We found that incidents were recorded in patients' daily records. However, we found an incident that had been reported on the wrong day.

## Are Wards for people with learning disabilities or autism effective?

Inadequate 

### Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of patients who would benefit. They worked with patients and with families and carers to develop individual care and support plans and updated them as needed. Care plans reflected the assessed needs, and were personalised and strengths based.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. The hospital uses the short-term assessment of risk and treatability (START) to assess each patient. We found that the hospital used other assessment tools that are in line with best practice.

Care plans were personalised. However, we found key information about a patient's history which had been missed from their care plan. There were inconsistencies in patients' care plans. There were gaps in information such as end of life wishes and cultural beliefs.

Patients' physical health needs were not fully assessed in their care plans. We found basic information stated in each patients' records.

Positive behaviour support plans were present and supported by a comprehensive assessment which were easily available for staff. However, we found that one patient's positive behaviour plan was not present.

### Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. However, staff did not always support patients with their physical health or encourage them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes but the focus was on mental health and behavioural problems.

# Wards for people with learning disabilities or autism

Staff did not always identify patients' physical health needs or record them reliably in their care plans. Information was recorded in both electronic and paper formats. Staff did not routinely refer to paper records to gain a comprehensive view of patients' needs.

Although the paper physical health plans required patients be weighed monthly, there were gaps where patients were not weighed with no explanation given to why. Some entries were incorrect, and managers were not aware of it. One patient's weight had dropped by 3kg since January 2021, her weights were incompletely and incorrectly recorded. Reviewing this patient's care plan, we found that although they had been seen by the GP there was no record of the reason behind the weight loss. We also found that the patients daily risk assessment did not reflect her current weight.

Staff had not made sure patients had access to physical health care, including specialists as required. There was no focus on prevention and early identification of health needs. One patient had not attended two cancer health screening appointments in January and staff had taken no action to rearrange them. Staff we spoke with said the patient would find the screening upsetting, but we found no evidence of a capacity assessment or a best interest meeting to support the patient to those appointments. Staff said they would arrange a capacity assessment.

Another patient had been to the emergency department with severe pain and although doctors there had said she needed to contact the specialist dealing with previous injuries, staff had taken no action for four days leaving the patient to rely only on pain relief. Again, there was no assessment of capacity to understand and decline the advice given or of a best interest's decision to support staff not taking any further action.

Staff provided a range of care and treatment suitable for the patients in the hospital. Therapeutic paid jobs were available for patients and education in maths and English.

Staff understood patients positive behavioural support plans and provided the identified care and support. However, we found one patient who did not have a positive behavioural plan in place.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. We found clear instructions and posters for the catering staff and staff gave examples of the dietary needs of a patient.

Staff did not always help patients live healthier lives by supporting them to take part in programmes or giving advice. Although the hospital had developed a weight loss session for patients, they did not record which patients attended or what weight they had lost. Care plans for some overweight patients said they needed to lose one to two pounds per week but there was no record of their progress or whether they even attended the weight loss sessions.

Staff used recognised rating scales to assess and record the severity of patients' mental health conditions and care and treatment outcomes.

## **Skilled staff to deliver care**

The hospital team included or had access to the full range of specialists required to meet the needs of patients. Managers had not made sure that all nursing staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Patients received care from staff who did not have the skills or experience that is needed to deliver effective care. We found gaps in specialist training for nursing staff.

# Wards for people with learning disabilities or autism

However, the hospital had (access to) a full range of specialists to meet the needs of the patients on the hospital. The responsible doctor, specialist doctor and psychologist were shared during the week with another Cygnet hospital. The hospital did have a part time speech and language therapist, an occupational therapist and an assistant psychologist who were solely based there.

Managers gave each new member of staff a full induction to the hospital before they started work. We found that induction packs were comprehensive and were completed whilst the new staff worked shifts at the hospital. We found that new staff had regular supervision.

Managers supported staff through regular supervision of their work. Managers supported medical staff through regular, constructive clinical supervision of their work and made sure staff attended regular team meetings.

## **Multidisciplinary and interagency teamwork**

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The hospital team had effective working relationships with staff from hospitals that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Site base staff met daily at the morning meeting and hospital rounds where the full multidisciplinary team would be present were held on Mondays and Wednesdays. Although staff shared information about patients and any changes in their care including risks, we found examples where the information shared was inaccurate.

Hospital teams had effective working relationships with other teams in the other parts of the Cygnet organisation.

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

Staff did understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff had access to up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. However, training figures showed that 18 out of 30 staff had accessed and completed the training.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

Patients had easy access to information about independent mental health advocacy. The advocate attended the hospital weekly.

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 stored copies of patients' detention papers and associated records correctly and staff could access them when needed. These records were securely locked away in the manager's office.

## **Good practice in applying the Mental Capacity Act**

# Wards for people with learning disabilities or autism

Staff did not always support patients to make decisions on their care for themselves. They did not understand the provider policy on the Mental Capacity Act 2005 and did not always assess and record capacity clearly for patients who might have impaired mental capacity.

Staff did not always understand how to assess if patients had the capacity to make decisions. Staff had access to up-to-date with training in the Mental Capacity Act and we found 18 out of 30 staff had completed the training. However, we found that where there could be a reasonable expectation that capacity would be assessed and if lacking, trigger a best interest's decision this had not been done. This was true of the concerns around accessing physical health care as detailed above.

## Are Wards for people with learning disabilities or autism caring?

Requires Improvement 

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

Staff treated patients with compassion and kindness. However, they had not always understood the individual needs of patients and failed to support patients to understand and manage their care, treatment or condition. Staff did not always respect patients' privacy and dignity.

Staff gave patients help, emotional support and advice when they needed it. We saw staff engaging patients whilst on observations and offered distraction techniques when patients became anxious. However, we found incidents where patients became aggressive, and staff used restraint.

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

Patients said staff treated them well and behaved kindly. However, all three patients we spoke with told us staff did not always knock before entering their bedrooms.

Staff had not understood and respected the individual needs of each patient.

### Involvement in care

Staff did not always involve patients in physical health care planning and risk assessment. However, staff actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

### Involvement of patients

Patients did not always receive a caring attitude by staff.

Staff involved patients and gave them access to their care planning and risk assessments. We found care plans that were person centred in their design. Patients were able to choose pictures and images that meant something to them, such as a favourite music star, animal or movie.

# Wards for people with learning disabilities or autism

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Patients had different communication needs and staff provided a variety of different formats to suit the individual needs of all patients. Staff produced easy read versions of care plans for patients.

We saw evidence that staff offered debriefs following most episodes of restraint although they were mainly (61%) declined.

Staff involved patients in decisions about the hospital, when appropriate. We read records of patients' community meetings where patients raised suggestions and complaints. However, records show that in the meetings held in March, April and May 2021 not all the patients view points or feedback was sought.

Staff had not supported patients to make decisions on their care. Staff invited patients to their care programme approach meetings and recorded patients' views in their care plans. However, we found patient views around physical healthcare had not been consulted on.

Staff made sure patients could access advocacy whilst in the hospital. Patients told us that the advocate was on site each week and available for them to speak to.

## Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Carers told us that staff were approachable, and they could call when they needed to. They told us that their loved ones told them about their care and treatment.

Staff did not always give families feedback on the hospital. Carers told us that they received an evaluation form occasionally.

## Are Wards for people with learning disabilities or autism responsive?

### Access and discharge

Staff planned and managed discharge well. They liaised well with hospitals that would provide aftercare and were assertive in managing the discharge care pathway. Although discharge was managed well patients did have excessive lengths of stay and discharge was delayed due to clinical reasons.

### Bed management

Managers regularly reviewed length of stay for patients and acknowledged excessive lengths of stay for patients. Delays were to do with patients not engaging into the programme of rehabilitation and also difficulty finding appropriate placements.

# Wards for people with learning disabilities or autism

The hospital had out-of-area placements and planned discharges back to the patient's home area and their home care team.

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

Patients were moved between different hospitals during their stay only when there were clear clinical reasons, or it was in the best interest of the patient. Managers supported transition well when a patient was transferred to a different hospital. Staff did not move or discharge patients at night or very early in the morning. The hospital had recently admitted a patient from another hospital and arranged for their staff to support the patient at the hospital to allow for a smooth transition of care. The patient told us that they felt it went well.

## **Discharge and transfers of care**

Managers monitored the number of delayed discharges. These were discussed in patients' hospital round meetings so that the patient and family could also be involved.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

## **Facilities that promote comfort, dignity and privacy**

Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. However, one of those spaces was not available at the time of our inspection. The food was of good quality and patients could make hot drinks and snacks at any time.

The hospital had a lounge area, large dining room, multi faith room, an assisted living kitchen and an assisted living laundry. There was a large garden with access to a polytunnel and a sensory shed. Patients' rooms were spacious and had en-suite facilities. Patients had a secure place to store personal possessions. Although we did find that a patient had her belongings locked away in the multi faith room. Managers were sourcing another area more suitable to store their belongings.

Patients had access to a shower in their en-suite bathroom. The hospital had quiet areas and a room where patients could meet with visitors in private. However, one room was not available for patients and the patients we spoke with told us that they liked the room as a place to relax as their bedrooms can be noisy if incidents were occurring.

Patients could make phone calls in private. Most of the patients we saw had access to their own mobile phones.

Each patient had their own bedroom, which they could personalise. We found patients had been able to have pictures up and have their own choice of bedding.

The hospital had an outside space that not all patients could access easily. Although ramps were present there were some areas in the garden that had uneven steps and would present a hazard for anyone with mobility difficulties. Individuals with compromised mobility or disabilities where mobilising is difficult were not admitted to the unit because of challenges relating to the built environment.

**T**here was a large garden with access to a polytunnel and a sensory shed.

# Wards for people with learning disabilities or autism

Patients we spoke with thought the food was good and a healthy choice was offered. Staff told us that the food was locally sourced. Patients were supported by staff to make meals and their own hot drinks and cold drinks were available throughout the day and night. Following an individual risk assessment patients were given a fob to access the therapeutic kitchen to make their own snacks and drinks independently.

## **Patients' engagement with the wider community**

Staff supported patients with activities outside the hospital, such as work, education and family relationships.

Staff helped patients to stay in contact with families and carers. During the COVID-19 pandemic both patients and carers told us that they had kept contact with their families through phones and video calls. More recently patients had been able to have visitors by following local COVID-19 guidelines.

Staff encouraged patients to develop and maintain relationships both in the hospital and the wider community. Although the COVID-19 pandemic had meant restrictions on socialising we found that patients had been supported to go and meet friends out in the community and were provided with COVID-19 information and how to follow the guidelines, these guidelines were also made in an accessible format for patients who needed them.

## **Meeting the needs of all people who use the hospital.**

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

The hospital could support and make adjustments for disabled people. However, we found some areas of the hospital and the grounds were not suitable for patients with physical disabilities. Access into the hospital was difficult and corridors were low in height and narrow. Parts of the garden were not accessible due to steps. These challenges were taken into account in the provider's admission policy and individuals with compromised mobility or disabilities where mobilising is difficult were not admitted to the unit.

Staff understood the Accessible Information Standard (AIS) and ensure it is implemented. The multidisciplinary team had produced a lot of easy read documents for patients. There were also easy read posters around the hospital to support patients.

The hospital provided a variety of food to meet the dietary and cultural needs of individual patients. The catering staff told us that they could cater for different needs and there were resources on different dietary illnesses on the training learning resource library.

Patients had access to spiritual, religious and cultural support. Although the multi-faith room was out of use due to it being used as a storage area for a patient's belongings.

## **Listening to and learning from concerns and complaints**

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

# Wards for people with learning disabilities or autism

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers would meet with patients to explain what had happened. Patients told us that they could speak to managers about problems. However, we found a complaint from a patient that wasn't dealt with. We raised it to the local safeguarding team as the complaint was regarding potential financial abuse.

Patients, relatives and carers knew how to complain or raise concerns.

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

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

Inadequate 

### Leadership

Leaders did not demonstrate they had the skills, knowledge and experience to perform their roles. They did not have a good understanding of the hospital they managed. They were visible in the hospital and approachable for patients and staff.

Leaders did not demonstrate they had the skills, knowledge and experience to perform their roles. Our findings from this inspection showed that the registered manager had not taken action to ensure that patients physical health, safety and staff training was being effectively managed. We found that the staff did not have the specific training to meet the needs of the patients including training in learning disability, autism, personality disorder and bipolar disorder.

We found that the frequency of attendance from the local police was high. In a patient's care plan, we found that the police were to be used for the protection of staff and others with no reference to utilising the positive behaviour support plan or de-escalation techniques.

### Vision and strategy

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

Some staff told us that they understood the vision and values of the provider. They received emails with regular updates. However, they felt that the amount information they received could be overwhelming and didn't have enough time to be able to catch up with the messages sent. We were told by staff that senior members often visited the site. The registered manager was visible on site, however staff told us they would often be in their office which was situated away from the main building of the hospital.

### Culture

Staff did not always feel respected, supported and valued. Two thirds of the staff (four out of six) we spoke with told us they did not always feel respected, supported and valued. However, in a staff survey from March 2021, 66% of staff reported being supported by the manager, 69% being valued by the manager at 69%, and 72% being respected by the manager.

# Wards for people with learning disabilities or autism

During the inspection, staff said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear. However, they said that although they felt listened to, actions were not implemented or fed back to them. The staff told us they operated as two teams to cover the hospital and they felt sometimes information can be missed. Communication was inconsistent. During the inspection, we found a patient in distress and displaying behaviours that challenge, due to the miscommunication between the two teams.

## Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

The registered manager held monthly clinical governance meetings with the multidisciplinary team. We found in May's meeting managers had noted barriers in communication between the team and support staff. They also recognised having a part time multidisciplinary team had created barriers in hospital development. There was no mention on how this would be resolved or actions to complete. Overall, we saw that actions were limited and the evidence for assurance incomplete. For example, an action to email team leaders to ensure they had identified support to attend ward rounds was marked as completed although it was noted there was no response.

Despite the sufficient challenges in aggression by patients with the result of police becoming involved there had been no mention of theme and trends in the monthly clinical governance meetings.

We found that known risk around ligature points from learning from death reviews at other Cygnet hospitals had not been implemented at Cygnet Views and risk assessed against the patient group at Cygnet Views. This demonstrated a lack of effective corporate governance to ensure lessons were learnt across the group.

## Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Teams had access to the information they need to provide safe and effective care. However, we found issues in the information provided. Although there were audits completed by managers, we found records that were inconsistent and incorrect, and they were not picked up and actioned on.

## Information management

Staff collected data about outcomes and performance. However, we found that there was no effective local use of this data in identifying areas for quality improvement.

During our inspection we found that one patient's daily risk assessment had incorrect and misleading information. The information was about medication the patient was prescribed, this created the potential of a medicine error. This had not been recognised by managers or staff.

Although data was being collected by the multidisciplinary team, we found during the inspection that there was no audit on patients' physical health records. Subsequently, the provider sent us an updated, unsigned physical healthcare audit, showing high level of compliance across four patient care records. As the audit was anonymised, we could not

# Wards for people with learning disabilities or autism

corroborate this evidence against our own findings and the physical health records submitted for individual patients. It was also evident that the audit had not been completed in line with the providers own user guidance. The only omission identified in that audit was the failure for all cases considered to complete a blood test within 24 hours of admission. No actions were raised to address this.

## Engagement

There was minimal engagement with people who use services, staff, the public or external partners. The service does not consistently respond to what people who use services, or the public say. Clinical governance records showed that patients viewpoints were sought. However, not every patient's viewpoint was sought, and no evidence was found to see how staff would gain their opinion. No actions were put against, or acknowledgment of feedback given.

## Learning, improvement and innovation

There was little innovation or service development, no knowledge or appreciation of improvement methodologies, and improvement was not a priority among staff and leaders. There was minimal evidence of learning and reflective practice. The impact of service changes on the quality and sustainability of care was not understood. There had been no opportunities for research or learning identified in the clinical governance minutes. The hospital did not participate in accreditation schemes relevant to the service and learned from them.

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

Treatment of disease, disorder or injury  
Assessment or medical treatment for persons detained under the Mental Health Act 1983

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance  
**Patient's records had gaps and were not fit for purpose.**  
There was no meaningful audit of patients physical healthcare plans. The monthly clinical governance meeting did not table, review or action any clinical audits.

#### Regulated activity

Treatment of disease, disorder or injury  
Assessment or medical treatment for persons detained under the Mental Health Act 1983

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment  
**The ligature risk assessment did not identify all potential ligature points in the hospital.**  
The provider had failed to consistently weigh patients and support programmes of weight gain or loss (as appropriate) to reduce longer term health risks highlighted in this patient group.

#### Regulated activity

Treatment of disease, disorder or injury  
Assessment or medical treatment for persons detained under the Mental Health Act 1983

#### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care  
**Patients' physical health needs were not fully assessed in their care plans. Where a patient lacked the capacity to make a decision about their physical health needs their best interests were not considered and acted on.**  
Key information about one patient's history had been missed from their care plan.

This section is primarily information for the provider

# Requirement notices

There were gaps in information in care plans such as end of life wishes and cultural beliefs.

| Regulated activity                                                                    | Regulation                                                                                                |
|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| Treatment of disease, disorder or injury                                              | Regulation 18 HSCA (RA) Regulations 2014 Staffing                                                         |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 | <b>The provider did not ensure that staff had the specialist training needed to meet patient's needs.</b> |