Cygnet Hospital Colchester

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?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Overall summary

Cygnet Hospital Colchester is a 54-bed hospital for men aged 18 years and above based in Colchester, Essex. There are three core services: acute wards for adults of working age; long stay rehabilitation mental health wards for working age adults and wards for people with a learning disability or autism. We undertook a focused inspection of this service to check the provider had completed agreed actions after we issued a section 29 warning notice at our last inspection in November 2019, when we told the provider it must take action to: make improvements to their systems for reviewing or investigating staff restraints on patients; ensure that staff followed patients' management plans and ensure that staff involved in incidents made accurate reports.

At our inspection in November 2019 we rated the provider inadequate overall. The provider had already been placed in special measures at a previous inspection in May 2019. We did not rate the hospital at this inspection, so the rating remains the same and the provider remains in special measures.

Summary of findings

The warning notice related to Ramsey ward, a long stay rehabilitation mental health ward for working age adults. Our findings also apply to other services, we do not repeat the information but cross-refer to the long stay rehabilitation mental health wards for working age adults service level.

At this inspection we found the following area still needed improvement:

- The provider's system for checking closed circuit television (CCTV) to review staff restraints on patients was still developing and embedding. Senior staff lacked a clear understanding of the process for checking CCTV and had therefore had not clearly communicated this to staff. Staff described different versions of how the system operated. The provider did not have a clear policy for staff to follow and was not auditing its implementation. The provider's system relied on closed circuit television footage being available for managers to check. There was not a robust system in place to check this was working. There were two occasions in March 2020 where it was not available due to a system's failure on Highwoods ward and on Oak Court.
- We checked two patients' care and treatment records and found their positive behavioural support plans did not give clear information to staff about how best to support the patient to reduce the need for restraint. For example, they did not capture information held elsewhere in the patients' notes about their specific communication needs.
- Staff did not always fully complete incident reports. For example, we found 16 examples when the nurse in charge or ward manager had not documented their review of staff actions. This posed a risk that staff actions might not be fully effective to reduce risks. Staff had not always signed reports or given start and end times when incidents occurred. The provider did not have clear archive systems to ensure easy tracking of incident forms. Staff gave us reports often not in chronological order of completion. Staff did not always detail linked incident report references when more than one person was involved in an incident, as was in their policy.
- In addition, we found that most bank nurses, had not completed safeguarding training relevant for their role. This posed a risk staff would not know how to identify and report incidents of abuse towards patients.

However, we found that the provider had made the following improvements:

- The provider had systems in place to safeguard patients and for staff to reflect on incidents and escalate any issues that concerned them or any improvements in practice that could be made following incidents.
- We did not observe any incidents which indicated that inappropriate staff restraint or abuse of patients had occurred, either when checking closed-circuit television footage or during ward visits.
- The provider had made improvements to its incident reporting processes. The provider monitored themes and trends. They had completed thematic reviews to identify any actions required to reduce risks to patients and others. Managers shared learning from incidents with staff.
- Patients told us staff took time to speak with them after restraint about their experiences. We saw examples where staff treated all patients with kindness, dignity and respect on Highwoods, Ramsey and Oak Court.
- Additionally, the provider had recently increased leadership and senior management team at the hospital. The hospital manager had a clear means of communication to the executive board to raise any concerns and gain extra resources they needed.
- The provider had ensured that the majority of staff had completed de-escalation and restraint training.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement 	• Highwoods Ward has 19 beds and is an acute in-patient service.
Long stay or rehabilitation mental health wards for working-age adults	Inadequate 	• Ramsey ward is the largest ward with 21 beds and is a high dependency inpatient rehabilitation service.
Wards for people with learning disabilities or autism	Requires improvement 	• Oak Court has 10 beds for patients with a learning disability, associated complex needs and behaviours that challenge. • Larch Court has four beds and provides intensive support for patients with autism, learning disabilities and complex needs.

Summary of findings

Contents

Summary of this inspection

Page

Background to Cygnet Hospital Colchester 6

Our inspection team 8

Why we carried out this inspection 8

How we carried out this inspection 8

What people who use the service say 8

The five questions we ask about services and what we found 10

Detailed findings from this inspection

Overview of ratings 13

Outstanding practice 23

Areas for improvement 23

Action we have told the provider to take 25

Inadequate

Cygnet Hospital Colchester

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Long stay or rehabilitation mental health wards for working-age adults; Wards for people with learning disabilities or autism.

Summary of this inspection

Background to Cygnet Hospital Colchester

The location Cygnet Hospital Colchester is a 54-bed hospital for men aged 18 years and above based in Colchester, Essex. The provider is Cygnet Learning Disabilities Ltd. There are three core services:

Acute wards for adults of working age

- Highwoods Ward has 19 beds and is an acute in-patient service. The service is new and was opened on 16 September 2019.

Summary of this inspection

Long stay rehabilitation mental health wards for working age adults

- Ramsey ward has 21 beds and is a high dependency inpatient rehabilitation service.

Wards for people with a learning disability or autism

- Oak Court has 10 beds for patients with a learning disability, associated complex needs and behaviours that challenge. Four beds are for patients in short term crisis or those who no longer require acute care but remain on an acute ward. Five beds are for patients with high dependency needs and supports assessment, treatment and rehabilitation. There is a one bed apartment to provide a more independent living environment.
- Larch Court has four beds and provides intensive support for patients with autism, learning disabilities and complex needs.

Clinical teams give multidisciplinary input to both wards including nursing, occupational therapy, psychology, psychiatry and vocational training. The hospital has an off-site activity centre (Joy Clare).

This location is registered with the Care Quality Commission to provide 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. The provider is submitting an application for a controlled drugs accountable officer.

The Care Quality Commission carried out a focused inspection on Flower Adams 1 and 2 wards at this location on 9, 15 April and 2 May 2019. Breaches of The Health and Social Care Act2008 (Regulated Activities) Regulations 2014 were identified for:

- Regulation 12 Safe care and treatment
- Regulation 17 Good governance
- Regulation 10 Dignity and respect

The CQC placed urgent conditions on the location's registration and also issued a warning notice and requirement notices. The CQC placed the location in special measures on 20 May 2019. The provider sent the CQC their action plans outlining how they would address the breaches of regulations. They closed Flower Adams wards and the CQC removed the conditions.

Summary of this inspection

At the last comprehensive inspection 12,13,14 and 20 November 2019 we found the provider had taken actions to make improvements, but we identified breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for:

- Regulation 9 Person centred care
- Regulation 12 Safe care and treatment
- Regulation 17 Good governance

The provider sent the CQC their action plans outlining how they would address the breaches of regulations.

Additionally, we identified a breach of Regulation 13 safeguarding service users from abuse and improper treatment and issued a section 29 warning notice to the provider.

At this inspection, we identified the provider had taken some actions to address the warning notice. However, we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, for Regulation 17 good governance and Regulation 18 staffing.

Our inspection team

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

Why we carried out this 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 13 HSCA (RA) Regulations 2014 safeguarding service users from abuse and improper treatment. As this was a focused inspection, we have not reported on all the key questions and lines of enquiry.

How we carried out this inspection

We carried out this inspection over two days.

As this was a focused inspection, we have reported our findings under safe, caring and well-led domains. We did not inspect all key lines of enquiry.

During the inspection visit, the inspection team:

- reviewed incident reports from November 2019 to March 2020, and specifically tracked eight restraint incidents;
- spoke with five patients including ward patient representatives;
- spoke with the registered manager, clinical service manager, operations director, regional nursing director, a hospital restrictive interventions lead, the corporate restrictive interventions lead and the hospital safeguarding consultant;
- looked at two patients' care and treatment records;
- 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 five patients who provided mixed feedback. Patients told us there were more staff to support them in the week than at weekends and at night. Some told us how staff were kind and friendly to them. Others told us night staff were less supportive.

Patients told us they did not like being restrained, but that staff talked to them afterwards about their

Summary of this inspection

experiences. Two patients told us staff could give them more support than they had received, for their physical healthcare needs. The provider had completed a patient survey and were analysing the results.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We did not rate the service at this inspection. The ratings detailed in this report related to the comprehensive inspection in the November 2019.

We found areas of practice still require improvement:

- The provider's system for reviewing staff restraints on patients, by checking closed circuit television to ensure staff used appropriate techniques still needed development and embedding.
- Two patients' positive behaviour support plans did not give clear information to staff about how best to support the patient to reduce the need for restraint. For example they did not capture information held elsewhere in the patients notes about their specific communication needs such as the use of Makaton.
- Some staff had not accurately completed incident reports as per the provider's policy. For example, there were 16 occasions when the nurse in charge or ward manager had not documented their review of the reports to indicate that staff's actions taken were appropriate. This posed a risk that actions taken might not be fully effective to reduce risks. The provider did not have clear archive systems to ensure easily tracking of incident forms. Staff had not ensured all incident reports had supporting documentation to indicate patients and staff were routinely offered debriefs after restraint incidents to identify any risks or areas of support.
- In addition, not all staff had completed safeguarding training relevant for their role. For example, 60% of bank nurses had not completed safeguarding level two and three training. This posed a risk staff would not know how to identify and report incidents of abuse towards patients.

However, we found that the provider had made the following improvements:

- The provider was introducing an electronic incident reporting system from 1 April 2020, to ensure consistency across all sites and make it easier to identify themes and trends. Managers gave staff training and information to help improve incident reporting.
- The provider had systems for staff to report safeguarding incidents and have them investigated. They had regular contact with the local authority regarding incidents. Managers were

Summary of this inspection

changing night time staffing rotas to ensure staff worked on both day and night shifts, to help reduce the risk of a closed culture forming. Managers gave examples of checking staff's competency for their work and where they used their staff performance management process to ensure staff worked to the provider's required standard.
- The provider ensured that most staff had completed de-escalation and restraint training.

Are services effective?

Requires improvement

This was a focused inspection to specifically check on the provider's actions after the CQC had issued a section 29 warning notice. We did not inspect this key question.

Are services caring?

Requires improvement

We did not rate the service at this inspection. The ratings detailed in this report related to comprehensive inspection in the November 2019. We did not use our usual comprehensive inspection method of asking patients when we were on the wards to speak with us as we only went to wards to check closed circuit television. Instead we met with ward patient representatives, and also another patient gave us feedback.

We found areas of practice that still require improvement:

- At this inspection, some patients told us night staff were less supportive, and that there were less staff available for them at nights and weekends.
- Two patients told us staff could give them more support with their physical healthcare needs.

However, we found that the provider had made the following improvements:

- Some patients told us staff were kind and friendly to them.
- We saw examples where, staff treated all patients with kindness, dignity and respect on Highwoods, Ramsey and Oak Court. For example, we saw Ramsey ward staff considering a patient's dignity during restraint.

Are services responsive?

Requires improvement

This was a focused inspection to specifically check on the provider's actions after the CQC had issued a section 29 warning notice. We did not inspect this key question.

Are services well-led?

Inadequate

We did not rate the service at this inspection. The ratings detailed in this report related to comprehensive inspection in the November 2019.

Summary of this inspection

We found areas of practice that still require improvement:

- The provider's system for the review or investigation of reported staff restraints on patients was still developing and embedding. The provider was not auditing the implementation of the system. Not all staff knew what the system was and there was not a policy they could refer to.
- The provider did not have systems to regularly check that closed circuit television was working. This was problematic as managers were reliant on closed circuit television footage being available for them to assist them in their review of restraint incidents. We found two occasions where it was not available due to systems failure, 5 March 2020 Highwoods and 1 March 2020 on Oak Court.

However, we found that the provider had made the following improvements:

- The provider had recently increased the leadership and senior management team at the hospital. The hospital manager had a clear means of communication to the executive board via fortnightly telephone meetings. The hospital manager had easier access to get finance and staff to make improvements.
- The provider had implemented a system to check if staff were using appropriate restraint techniques. They acknowledged that it still needed some work to make it more effective. The hospitals' monthly patient safety group meeting minutes for February 2020 showed staff were reviewing incidents, for example, restraint and safeguarding to identify learning to reduce the risk of reoccurrence.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Wards for people with learning disabilities or autism	Inadequate	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate

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

Requires improvement

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

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

Requires improvement

This was a focused inspection to specifically check on the provider's actions after the CQC had issued a section 29 warning notice. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service.

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

Good

This was a focused inspection to specifically check on the provider's actions after the CQC had issued a section 29 warning notice. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service.

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

(for example, treatment is effective)

Good

This was a focused inspection to specifically check on the provider's actions after the CQC had issued a section 29 warning notice. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service.

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

(for example, to feedback?)

Good

This was a focused inspection to specifically check on the provider's actions after the CQC had issued a section 29 warning notice. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service.

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

Requires improvement

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

Requires improvement

This was a focused inspection to specifically check on the provider's actions after the CQC had issued a section 29 warning notice. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

Are long stay or rehabilitation mental health wards for working-age adults safe?

Inadequate

Assessing and managing risk to patients and staff

The provider had implemented a system for checking closed circuit television to review staff restraints on patients to check that staff used appropriate techniques and were not abusive. The system was still developing and embedding. We identified issues related to senior staff's understanding and communication of the process and have detailed this in the well led section of our report.

As this was a focused inspection, we checked staff incident reports for all three core services, following our November 2019 inspection to March 2020, to identify and track a sample of staff restraints on patients. Provider information for December 2019 to 11 March 2020 showed there were 80 reported incidents of staff restraint on patients. Highwoods ward had the highest amount with 38, Oak Court had 32, Ramsey ward had six and Larch Court had the lowest with four incidents reported. Staff identified what incidents to review at twice daily situational report meetings during the week. Managers logged their review of these incidents on a tracker.

Due to time limited closed-circuit television footage being available, we tracked eight incidents of reported restraint for Highwoods, Ramsey and Oak wards. We did not identify significant inaccuracies when reviewing information held in these incident forms with available closed-circuit television footage. However, through tracked incidents of restraint for two patients' (Oak Court and Ramsey ward), we found both patients' positive behavioural support plans did not give clear information to staff about how best to support the patient to reduce the need for restraint. For example, they did not capture information held elsewhere in the patients notes about their specific communication needs such as use of Makaton. Ramsey ward staff had identified some information as an intervention as opposed to a trigger. This posed a risk staff would not know the best way to support them if they were unsettled. Oak Court's plans were not as detailed as those seen for Ramsey ward.

Staff told us that following staff restraints of patients, they and patients would be offered a debrief. We saw examples of paper documents confirming this. However, we did not see all incidents had these documents. It was apparent that the provider was still developing this process. There was no apparent debrief for the staff or patient for a 25-minute incident. We also noted it was inaccurately recorded as 10 minutes on the provider's tracker.

The provider ensured that most staff had completed de-escalation and restraint training. Provider information as of 10 March 2020 for restraint training showed Ramsey and Highwood ward staff achieved 100% compliance; Oak Court achieved 96% compliance; Larch Court achieved 91% compliance, bank staff achieved 98% compliance and allied health professionals achieved 84% compliance. Staff told us the focus of the training was to first try and verbally de- escalate incidents to reduce the need for physical restraint. Additionally, managers and hospital restraint leads made checks of staff's competency to use restraint through a review of closed-circuit television and ward simulation exercise 'drills' held twice a month (evidence not seen).

The provider had a reducing restrictive practice policy dated April 2018, which referenced Department of Health

and Social Care guidance and The National Institute for Health and Care Excellence guidance. None of the reported incidents documented that staff held patients in a prone (face down) position. Staff told us this was not an approved restraint technique in the hospital.

Safeguarding

Not all staff had completed safeguarding training relevant for their role. This posed a risk that staff would not know how to identify and report incidents of abuse towards patients.

For safeguarding level two training:

- Forty percent of bank nurses and 67% of bank unregistered nurses were compliant with this training.
- Allied health professionals had achieved a combined 64% compliance with doctors having the lowest compliance with 25% and speech and language staff having the highest compliance with 100%.
- Highwoods ward had 76% compliance; Larch Court had 77% compliance; Oak Court and Ramsey ward had the highest ward staff compliance with 85%.

For safeguarding level three training:

- Only 40% of bank nurses were compliant with this training.
- Larch Court had the lowest with 60% compliance; Ramsey ward had 67% compliance; Highwoods ward had 71% compliance; and Oak Court had the highest compliance with 80%.
- Over 75% of allied health professionals were compliant with this training.

The provider had systems in place to safeguard patients and for staff to report any abusive incidents found when they reviewed staff restraints on patients. At this inspection, staff we spoke with confirmed that following their random checks of restraints and closed-circuit television footage, they had not identified any occasions which required a safeguarding alert to be made. We also confirmed this through checking the provider's safeguarding alert log for the hospital. We did not observe any incidents which indicated that inappropriate staff restraint or abuse of patients had occurred, either when checking closed-circuit television footage or during ward visits. We saw one incident on Oak Court where staff reviewed and adjusted their restraint holds and the position of the patient to ensure it was appropriate.

The provider had temporarily employed an interim safeguarding consultant since July 2019. The hospital manager was the designated safeguarding lead. They had tried to recruit a social worker but so far were unsuccessful. The safeguarding consultant had developed systems to monitor and track safeguarding concerns investigations and outcomes. They reviewed incidents at twice daily situational report meetings to identify if the local authority safeguarding team should be notified and if a safeguarding investigation should take place.

Managers had identified a need to change night time staffing rotas to ensure staff worked both day and night shifts. This was to ensure a consistent approach between staffing shifts and to reduce the risk of a closed culture forming. Managers gave examples of checking staff's competency for their work and where they used their staff performance management process to ensure staff working for them were of the provider's required standard. The provider carried out a 'culture survey' in the hospital November 2019 with 31 staff responses. The most positive response related to 30 staff (97%) who identified staff behaved appropriately towards people using the service. The most negative response was 13 staff (42%) considered senior staff did not spend a substantial proportion of their working day interacting directly with people.

Provider information since our last inspection from 21 November 2019 to 11 March 2020, showed that the Local Authority was contacted about 53 safeguarding concerns identified for patients (Note: not all necessarily related to an allegation of abuse at the hospital). The provider had regular meetings with the Local Authority safeguarding teams to review the provider's investigation and actions. The majority of concerns (29) related to patients on Highwoods, the acute admission ward. This ward had more acutely unwell patients and also had a higher turnover of patients due to a shorter admission period compared with the other wards. The hospital had 29 open safeguarding investigations. Highwoods ward had 15; Ramsey ward had seven; Oak Court had six and Larch Court had one. Twenty-four safeguarding investigations were closed: Highwoods ward had 14; Ramsey ward had eight and Oak Court had two closed.

Reporting incidents and learning from when things go wrong

We checked staff paper incident reports for all three core services following our November 2019 inspection to March

Long stay or rehabilitation mental health wards for working age adults

Inadequate

2020, to identify and track a sample of staff restraints on patients. We found overall the provider had acted to improve the quality of information in reports. However, we found 16 occasions: 12 for Highwoods ward and four for Ramsey ward, when the nurse in charge or ward manager had not identified the actions required to reduce the risk of reoccurrence. This was not in line with the provider's 'Incident procedure in hospital's' policy dated 14 January 2019. This posed a risk that actions taken might not be fully effective to reduce risks. Following our feedback on site, the hospital manager circulated guidance to staff to improve this issue.

We found four incident forms for Ramsey ward, where the date of completion or review was missing. Three incident reports for Oak Court and two for Ramsey ward had either a missing start or end time for the incident. In order to improve the quality of incident reporting, the provider gave staff training on how to complete an incident form and had developed a 'hints and tips' sheet to assist staff. Managers had also circulated to staff a 'lessons learnt' briefing document to remind staff to improve the quality of reports. They had developed an incident report tracker, which senior staff reviewed at monthly patient safety group governance meetings.

The provider did not have clear archive systems to ensure easy tracking of incident forms. Staff gave us reports often not in chronological order of completion. The provider's policy stated that there should be linked incident reports for incidents involving two patients or staff, but we had difficulty locating them. Not all forms held another reference number to indicate another form was completed. Managers acknowledged these issues. The provider was introducing a new electronic incident reporting system across all their hospitals from 1 April 2020. They anticipated it would give automatic prompts to staff to reduce information gaps.

The provider monitored themes and trends for incidents. Provider information for 1 January to 11 March 2020 showed there were 19 incidents of patient assault on staff, Oak Court had the highest amount with eight (five incidents for one patient), Ramsey ward had five, Larch Court had four and Highwoods ward had two incidents. They had completed a thematic review of incidents for Oak Court on 5 February 2020 and had identified learning and actions to be taken. For example, improving staff risk assessment and positive behaviour support plans for patients.

Additionally, the provider had completed a thematic review of 15 incidents relating to patients' community leave: nine for Highwoods ward and six for Ramsey ward. These mostly related to patients failing to return from unescorted leave at the correct time. The provider was in the process of reporting on this to identify any good practice or learning to share with staff.

Are long stay or rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Requires improvement

This was a focused inspection to specifically check on the provider's actions after the CQC had issued a section 29 warning notice. We did not inspect this key question.

Are long stay or rehabilitation mental health wards for working-age adults caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

As this was a focused inspection, we did not use our usual comprehensive inspection method of asking patients when we were on the wards to speak with us, as we only went to wards to check closed circuit television. Instead we met with ward patient representatives, and also another patient gave us feedback.

We spoke with five patients. We gained mixed feedback from them. Patients told us there were more staff to support them in the week than at weekends and at night. Some told us how staff were kind and friendly to them. Others told us night staff were less supportive.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Patients told us they did not like being restrained, but that staff talked to them afterwards about their experiences. Two patients told us staff could support them more with their physical healthcare needs. The provider had completed a patient survey and were analysing the results.

We saw examples where staff treated all patients with kindness, dignity, respect on Highwoods ward, Ramsey ward and Oak Court. We observed some staff interactions with patients when we visited the hospital. We checked closed circuit television footage of staff's restraint of eight patients. For example, we saw Ramsey ward staff protecting a patient's dignity during restraint . Staff moved the patient away from a communal area to a more discreet location. They considerately moved furniture to reduce the risk of the patient (or staff) injuring themselves as it was a small area.

Are long stay or rehabilitation mental health wards for working-age adults responsive to people's needs?

(for example, to feedback?)

Requires improvement

This was a focused inspection to specifically check on the provider's actions after the CQC had issued a section 29 warning notice. We did not inspect this key question.

Are long stay or rehabilitation mental health wards for working-age adults well-led?

Inadequate

Leadership

Staff gave us feedback that the provider had recently increased the leadership and senior management team at the hospital. The hospital manager had a clear means of communication to the executive board via fortnightly telephone meetings. The hospital manager had easier access to get finance and staff to make improvements. Managers told us that in order to make effective changes to improve the hospital's performance they had told their senior managers they needed additional resources.

The provider had recently recruited a regional manager who gave management support to the hospital manager. The regional manager now had oversight of the three provider's hospitals in Essex and were accountable to the operations director. The hospital additionally had employed two interim clinical leads in post for three to six months. The provider had recruited a new manager, consultant psychiatrist and psychologist for Ramsey ward. Interviews were taking place to appoint a quality assurance manager to work across the three hospitals. Additionally, the provider had given the hospital additional funds to employ a ward grade doctor.

The chief executive, director of nursing and chief operation officer had visited the hospital since our last inspection. During this inspection the regional director of nursing and the newly employed lead for restrictive practice was on site meeting staff and giving support.

Governance

The provider had established a system for the review or investigation of reported staff restraints on patients. There was some written guidance for staff about the process. The provider had developed a monthly observation/ engagement and closed-circuit television audit to help improve the process and give greater senior management and provider oversight of any risks. However, this was still "work in progress". Over time, they had amended the process to make it more manageable as sometimes closed-circuit television was not available. It took more time than was originally anticipated to navigate the ward systems to find the incident. We found the system was not fully communicated with staff. Different staff gave us slightly different versions of how the system operated. For example, staff gave varying information as to whether the process was to review all restraints or a sample; whether or not hospital restraint leads should be involved to assess if staff were using the appropriate restraint techniques, and whether incidents should be reviewed within 24 or 72 hours. This process was in its infancy and further review was required to ensure effectiveness.

The operational director and regional nursing director clarified that managers would review a sample of restraints. Incidents were discussed at the twice daily situational report meetings, where managers decided which incidents to review via closed circuit television. However, there was no specific criteria for staff to follow. We checked minutes from these meetings and whilst it was evident staff

discussed restraint incidents, minutes did not identify if any required review by managers. Managers told us the provider had emailed hospitals to inform staff to start this process in 2019. However, they were unable to show us a copy of this communication. The provider had not developed a policy for staff to follow to ensure adherence with this request.

The tracker showed 37 incidents from October 2019 to March 2020. The provider had attempted to review incidents historically but were unable to complete earlier reviews as no closed-circuit television footage was available, due to the lapse of time. Additionally, staff could not review five incidents as there was no closed-circuit television footage available at all. For example, if the incident had occurred on Larch Court, where no closed-circuit television was available. We found 19 incidents of restraint which were not on the provider's tracker and where managers had not reviewed closed circuit television footage.

The provider had monthly patient safety group meetings and latest meeting minutes dated 17 February 2020 detailed information about manager's reviews or investigation of restraint incidents.

Management of risk, issues and performance

The provider's system for reviewing staff restraint of patients was not fully effective as it relied on closed circuit television footage being available for managers to check. Staff told us there was not a routine inspection to check closed circuit television was working. We found two occasions where it was not available due to systems failure, 5 March 2020 on Highwoods ward and 1 March 2020 on Oak Court. Ramsey ward's footage timings were inaccurate by 13 minutes.

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Inadequate

This was a focused inspection to specifically check on the provider's actions after the CQC had issued a section 29 warning notice. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service.

Are wards for people with learning disabilities or autism caring?

Requires improvement

This was a focused inspection to specifically check on the provider's actions after the CQC had issued a section 29 warning notice. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

This was a focused inspection to specifically check on the provider's actions after the CQC had issued a section 29 warning notice. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Good

This was a focused inspection to specifically check on the provider's actions after the CQC had issued a section 29 warning notice. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service.

Requires improvement

Wards for people with learning disabilities or autism

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

Requires improvement

This was a focused inspection to specifically check on the provider's actions after the CQC had issued a section 29 warning notice. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

We told the provider that it must take action to bring services into line with two legal requirements. This action related to all three core services.

- The provider must ensure that all staff know the system that should be followed for checking closed circuit television footage to review staff restraint incidents. Regulation 17(1)(2).
- The provider must ensure they assess, review and mitigate risks for their system of checking closed circuit television footage and reviewing staff restraint incidents. Regulation 17(1)(2).
- The provider must ensure closed circuit television is operating effectively. Regulation 17(1)(2).
- The provider must ensure staff reporting incidents follow the provider's policy, ensuring all incident reports are reviewed by managers or the nurse in charge. Regulation 17(1)(2).
- The provider must ensure that staff complete the required safeguarding training relevant for their role. Regulation 18(1)(2).

Action the provider SHOULD take to improve

Outstanding practice and areas for improvement

We told the provider that it should take action either because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The provider should ensure staff have clear information available in positive behaviour support plans to know how best to support patients. Regulation 17(1)(2).
- The provider should ensure staff and patients are routinely offered debriefs after incidents. Regulation 17(1)(2).

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 17 HSCA (RA) Regulations 2014 Good governance

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