Cygnet Newbus Grange

Quality Report

Hurworth Road
Neasham
Darlington
County Durham
DE2 1PE
Tel:01325 721951
Website: www.cygnethealth.co.uk

Date of inspection visit: 12 to 14 May 2019
Date of publication: 09/12/2019

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?	**Inadequate**
Are services well-led?	**Inadequate**

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Ted Baker
Chief Inspector of Hospitals

Overall summary

We rated Cygnet Newbus Grange as inadequate because:

- We have taken enforcement action against the registered provider in relation to our concerns about this location. This limits our overall rating of this location to inadequate.
- The staff at the hospital imposed a number of restrictions on patients. For example, no patient was allowed use a mobile phone, camera or tablet unless supervised by staff, to use ceramic crockery, to hold keys for their bedrooms or to access some parts of the building. Six patients were routinely denied access to their own possessions. This meant that their bedrooms were bare of the person's personal effects. These blanket restrictions were applied without having made individual assessments of the risks posed to individual patients. We therefore concluded that the service had inadequate systems and processes around restrictive practices. They did not have formal governance processes to identify, approve and review individual and blanket restrictions, and little documentation to record that these decisions were proportionate and the least restrictive option. At the factual accuracy stage, the provider submitted documents completed in July 2019 to show they had undertaken work to address these issues and had appointed a reducing restrictive practice lead.
- There had been a very substantial increase in the use of restraint since 2016. This was despite the provider having written a strategy to support a restrictive interventions reduction programme. We saw no evidence of this strategy having been turned into tangible action.
- Although the hospital had been taken over by Cygnet in August 2018, staff were still using the previous provider's policies and documentation at the time of our inspection. The medication policy had passed its review date and the on-call policy did not reflect national guidance on doctors' attendance to psychiatric emergencies.
- One patient was at risk of harm because staff had not ensured they had followed the medication policy for administering medication off-licence. They had not completed a risk assessment or produced a care plan for crushing a medicine and giving it in that form. Until we raised it with the provider, there was no mental capacity assessment or best interest decision in place for the administration of this medication.
- Patient safety, privacy and dignity was not a sufficient priority. Two patients' bedrooms did not have any blinds or curtains to protect their privacy and dignity and to allow them to block out natural light. There were safety risks from exposed blind cords in some bedrooms which had not been considered on the hospital's risk register and there were no actions to reduce or remove these risks following risk assessments.

Summary of findings

- Staff did not always demonstrate good practice when working with patients. Managers had identified both individual staff performance issues and general cultural issues with the staff team. These included staff sleeping while on duty and one incident of staff using inappropriate techniques when restraining a patient. Two carers told us that they had raised concerns around staff interactions. One member of staff described the hospital had a 'zero tolerance approach to wrong doing' culture and we were concerned this could make staff reluctant to bring forward concerns. We carried out 13 periods of observation of the interactions between staff and patients. These amounted to about five hours of observations. The analysis found that one-half of the interactions observed were poor or neutral. Staff did not respond to patients promptly, nor did they often initiate interactions or activities.
- The managers and staff did not do all they could to keep the hospital in a good condition. The interior of the building was worn and tired in places and some rooms smelt of damp or urine. Also, staff did not always follow good infection control practices in relation to food storage.
- We raised a safeguarding alert because two carers raised concerns about unexplained injuries to one patient and one carer raised concern about the same patient not receiving appropriate medical attention following an injury. The provider told us after this they had completed some monitoring at Newbus Grange instead of taking the patient the hospital for treatment.
- The hospital had a high staff turnover rate of 39%. In the 12 months prior to our inspection, 24% of shifts were filled by bank or agency staff. There was not enough substantive nursing staff to cover the shifts available.
- None of the staff had received training in immediate life support.

However:

- There was no reported use of seclusion, long-term segregation, rapid tranquilisation or prone restraint.
- Staff ensured that patients had easy access to physical healthcare.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Inadequate	

Summary of findings

Contents

Summary of this inspection

Page

Background to Cygnet Newbus Grange 7

Our inspection team 7

Why we carried out this inspection 7

How we carried out this inspection 7

What people who use the service say 8

The five questions we ask about services and what we found 9

Detailed findings from this inspection

Mental Health Act responsibilities 14

Mental Capacity Act and Deprivation of Liberty Safeguards 14

Overview of ratings 14

Outstanding practice 31

Areas for improvement 31

Inadequate

Cygnet Newbus Grange

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

Summary of this inspection

Background to Cygnet Newbus Grange

Cygnet Newbus Grange is an independent, specialist mental health hospital that provides assessment, care and treatment for patients with a primary diagnosis of autism, learning disabilities and complex needs. The hospital has 17 beds and accepts male patients. There were 10 patients at Cygnet Newbus Grange at the time of our inspection.

The hospital has been registered with the CQC since September 2013. It was taken over by Cygnet healthcare in 2018 (it had been previously managed by Danshell) and is registered to provide the following regulated activities:

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

The hospital had a registered manager who was the service manager and an accountable controlled drugs officer who was the regional nurse consultant.

The location has been inspected by the CQC four times previously. At our last inspection, we rated Newbus Grange as outstanding overall. We rated the key questions caring and well-led as outstanding and the key questions safe, effective and responsive as good. The provider was compliant with the regulations at our last inspection.

Our inspection team

The team that inspected the service comprised four CQC inspectors and one CQC Inspection Manager. The team members attended the service on different days.

Why we carried out this inspection

We inspected this service urgently following specific and significant concerns received about safety and culture within the other services managed by the provider in that region. This unannounced inspection was carried out at very short notice, which meant that we had insufficient time to make a request for an expert by experience on this inspection.

During our inspection, we identified additional concerns and we extended our focussed inspection to a comprehensive inspection.

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- visited all the service and looked at the quality of the ward environment
- carried out seven periods of observation using Short Observation Frameworks for Inspections and six other periods of observation;
- spoke with two patients who were using the service;

Summary of this inspection

- spoke with the registered manager and the deputy manager;
- spoke with the regional clinical director, regional director of psychology, regional director of occupational therapy and the national director of speech and language therapy also responsible for information management;
- spoke with 12 other staff members; including doctors, nurses, an activities co-ordinator, support workers, an occupational therapist and a psychologist;
- attended and observed one flash meeting;
- looked at six care and treatment records of patients:
- spoke with seven carers
- carried out a specific check of the medication management; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

The two patients that we spoke with told us that they liked it at Newbus Grange and they liked the staff.

We spoke with seven carers. Two carers told us that they had raised concerns about staff in the past because they did not feel that staff interacted with patients appropriately or enough. They told us that their concerns had been addressed when they raised this. Carers felt that managers were open and honest and acted to address any concerns.

Two other carers raised concern about one patient having unexplained injuries. One told us that staff had not sought medical attention for an injury they had sustained in an incident. We raised these concerns to the local authority safeguarding team and to the provider for investigation. The provider told us after this they had completed some monitoring at Newbus Grange instead of taking the patient the hospital for treatment.

Carers told us that staff made arrangements for them to visit patients, that they received important information when things happened and that they were invited to meetings to review patients' progress.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

- We have taken enforcement action against the registered provider in relation to concerns about safety in this service. This limits our rating of this key question to inadequate.
- Staff imposed a number of restrictions on patients. This included patients not being allowed to use a mobile phone, camera or tablet without staff supervision, to use ceramic crockery, to hold keys for their bedrooms or to access some parts of the building. Six patients were routinely denied access to their own possessions. This meant that their bedrooms were bare of the patient's personal effects. These blanket restrictions were applied without having made individual assessments of the risks posed to individual patients. We therefore concluded the service had inadequate systems and processes around restrictive practices. They did not have formal governance processes to identify, approve and review individual and blanket restrictions, and little documentation to record that these decisions were proportionate and the least restrictive option. However, at the factual accuracy stage, the provider submitted documents completed in July 2019 to show they had undertaken work to address these issues and had appointed a reducing restrictive practice lead.
- There had been a very substantial increased in the use of restraint since 2016. In the 12 months leading up to our inspection, there were 1,069 incidents of restraint. The provider having a written strategy to reduce the use of restrictive interventions, although there was no evidence that this had been turned into tangible action.
- One patient was at risk of harm because staff had not ensured they had followed the medication policy for administering medication off-license. They had not completed a risk assessment or produced a care plan for crushing medication and giving it in that form. Until we raised this, there was no off-license protocol in place.
- Patient safety was not a sufficient priority. The roller blind cords in patient bedrooms were exposed and could be a ligature risk or accidental hanging risk and this had not been recognised. The ligature risk assessments had not identified actions to remove or reduce this risk and this was not entered in the hospital's risk register despite the windows being on the risk register.

Summary of this inspection

- The managers and staff did not do all they could to keep the hospital in good condition. The interior of the building was worn and tired in places and some rooms smelt of damp and urine. We raised concern about food that was stored at room temperature and should be kept in a refrigerated and freezer and a soiled fabric chair in the clinic room.
- We raised a safeguarding alert because two carers raised concerns about unexplained injuries to one patient and one of these carers raised concern about the same patient not receiving appropriate medical attention following an injury. The provider told us after this they had completed some monitoring at Newbus Grange instead of taking the patient the hospital for treatment.
- The hospital had a high staff turnover rate of 39%. In the 12 months prior to our inspection, 24% of shifts were filled by bank or agency staff. There was not enough substantive registered nursing staff to cover the shifts available.
- The policy in use for on call doctors was not in line with national guidance and did not ensure a doctor could attend the hospital quickly in an emergency.
- None of the staff had been trained in immediate life support.
- Staff could not recall information on lessons learnt and team meetings did not demonstrate that staff received feedback on lessons learnt from incidents.

However:

- There had been no reported use of seclusion, long-term segregation or rapid tranquilisation. The hospital did not use prone restraint.
- Patients had positive behavioural support plans in place.
- When things went wrong, managers were open and transparent with relevant people and apologised.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- The great majority of staff providing direct care to these patients with complex needs were non-registered staff, support workers, that had received limited training. Furthermore, the service had a high turnover of these staff and a high proportion were not permanent employees. Managers had mandated only basic training to these staff in autism or in the interventions required to care for people with complex needs and behaviour that challenges. Our observations of staff interactions with patients were characterised by a failure to engage with patients

Summary of this inspection

or to initiate interactions. Also, there was no evidence that staff had managed to reduce the use of restrictive interventions – in fact the number of times that restraint was used had increased very substantially.
- Staff did not always follow the Mental Capacity Act and the five statutory principles. There was no capacity assessment or best interest decision in place for a patient prescribed a medication off-license until after our inspection when we had raised this with the provider.
- There were gaps in care planning. One patient did not have a care plan in place for a medication that was prescribed to be crushed and six patients care plans contained limited or no information about why their bedrooms contained limited or no personal possessions.
- Staff did not always demonstrate good practice when working with patients. Managers had identified both individual staff performance issues and general cultural issues with the staff team. This included staff sleeping while on duty and one incident of staff using inappropriate techniques when restraining a patient.

However:

- Staff ensured patients had access to physical health care and met the needs of patients who had special nutrition and hydration needs.
- Staff held regular multi-disciplinary team meetings.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- In our observations and SOFIs, 16 out of 33 frames demonstrated poor or neutral staff interactions with patients. This included patients having to repeat themselves multiple times before staff responded or acknowledged their communication. Staff did not initiate interactions with patients or engage in activity. This had also been raised with the staff team in March 2019 by the hospital manager.
- Two carers told us that they had raised concern to the manager about staff interactions with patients and two carers raised concerns to us about unexplained injuries to one patient.

However:

- Staff involved patients in their care and treatment as much as possible. They used communication aids to support patient involvement and involved carers, advocates and commissioners appropriately.

Summary of this inspection

- Staff involved carers appropriately. They ensured that carers received appropriate information, were invited to attend meetings about patient's care and treatment and supported patients to go out with their carers and families.

Are services responsive?

Inadequate

We rated responsive as inadequate because:

- We have taken enforcement action against the registered provider in relation to the responsiveness of care provided. This limits our rating of this key question to inadequate.
- Patient privacy and dignity was not a sufficient priority. Two patients' bedrooms did not have curtains or blinds. One patient's bedroom also did not any privacy frosting on their windows. Neither patient had any way to restrict natural light in their bedroom at all.
- Six patients were routinely denied access to their own possessions. This meant that their bedrooms were bare of the patients' personal effects. These restrictions were applied without having made individual assessments or the risk posed to individual patients. There was little or no documentation to record that these decisions were appropriate and the lease restrictive option. At the factual accuracy stage, the provider submitted documents completed in July 2019 to show that an occupational therapist had undertaken a review of five patients to try and address these issues.
- The food menu was written in very small text which was not easy to read for anyone especially someone with a learning disability.

However:

- Staff worked with external agencies to plan patients' discharges. In one case, there was a detailed transition care plan to ensure that the patient's discharge was positive and consistent to meet their needs.
- Staff met patients' specific communication needs using easy read information and staff had access to training in different communication methods.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- We have taken enforcement action against the registered provider following concerns about the governance and leadership of this service. This limits our rating of this key question to inadequate.

Summary of this inspection

- The hospital had inadequate systems and processes around restrictive practice. They did not have formal governance processes to identify, approve and review individual and blanket restrictions. We found that staff imposed a number of restrictions on patients without having made individual assessment of the risks posed to individual patients. There was little documentation to record that these decisions were proportionate and the least restrictive option. However, at the factual accuracy stage, the provider submitted documents completed in July 2019 to show that they had started to implement governance processes to identify, approve and review individual and blanket restrictions and they had appointed a reducing restrictive practice lead.
- The hospital did not have effective systems and processes to identify issues so that these could be addressed. We identified many issues during our inspection that managers had not identified previously and the issues that managers had been aware of had not been addressed by the time of our inspection.
- The risk register did not reflect all the risks in relation to the hospital's windows including, safety risk from the cords on the blinds and privacy and dignity issues where two patients did not have curtains or blinds in their bedrooms.
- Although the hospital had been taken over by the Cygnet group in August 2018, staff were unclear about the current vision and values and did not feel part of the group yet. All policies and documentation in place were the previous providers. Some of this was passed its review date and the on-call policy did not reflect national guidance on doctors' attendance to psychiatric emergencies.
- From January 2019, the hospital manager was also the regional manager which meant they could not spend as much time or focus on the hospital.
- Staff did not always demonstrate good practice when supporting patients and the manager had discussed this with staff in March 2019 after reviewing close circuit television which showed staff conduct falling below the standards expected. We found that this continued to be an issue.
- One member of staff told us that there was a 'zero tolerance approach to wrong doing' culture. We were concerned that could result in staff being reluctant to bring forward concerns.

However:

- Carers and staff told us that managers were visible and approachable.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Ninety one percent of staff had training in the Mental Health Act. Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had access to administrative support on the Mental Health Act and its code of practice. The hospital had its own administrators responsible for the Mental Health Act

Staff had access to the Mental Health Act policy and procedure which was available in the nurses' office.

Patients had access to information about mental health advocacy. This was displayed in an easy to read format in a notice board in the hospital's entrance hallway. Advocates also visited the service regularly and were invited to attend multi-disciplinary meetings.

Staff explained detained patients their rights in accordance with section 132 the Mental Health Act, they undertook this monthly and recorded when this had been completed and the outcome in patients' Mental Health Act files. Staff used easy read literature when explaining rights to patients.

Staff ensured that detained patients were able to take section 17 leave (permission granted for patients to leave hospital). Care and treatment records contained a section 17 leave form which outlined the conditions for the patients' leave directed from their responsible clinician.

Staff requested an opinion from a second opinion appointed doctor when necessary. Detained patients' records contained capacity to consent to treatment, assessment and valid certificates of consent. Relevant records contained a T3 certificate. A T3 certificate is issued by a second opinion appointed doctor appointed by the CQC where a detained patient cannot or will not consent to treatment. The second opinion appointed doctor reviews patients' circumstances including their views and the clinical appropriateness of the treatment before issuing a T3 certificate.

Staff stored copies of patients' detention papers and other associated records including section 17 leave forms and records on rights in accordance with section 132 in the patients' paper based Mental Health Act file.

The service displayed a notice to tell any informal patients that they could leave the ward freely. The front door to the hospital could be opened from the inside without a key or a code required.

Audits in the Mental Health Act were part of the hospital's audit schedule. These took place every six months and staff submitted these centrally to the provider and the quality assurance manager.

Mental Capacity Act and Deprivation of Liberty Safeguards

Ninety three percent of staff had received training in the Mental Capacity Act. Staff had a good understanding of the Mental Capacity Act but did not always apply it.

There were two deprivation of liberty safeguards applications and authorisations made in the 12 months leading up to our inspection to protect people without capacity to make decision about their own care. This was in line with the number of patients who were subject to deprivation of liberty safeguarding authorisations at the time of our inspection at the hospital.

Staff had access to a copy of the policy on the Mental Capacity Act and deprivation of liberty safeguards which was kept in the nurses' office.

Staff could seek advice from their colleagues on the Mental Health Act and the deprivation of liberty safeguards.

Staff told us that they gave patients every possible assistance to make decisions for themselves before they

Detailed findings from this inspection

assessed patients' capacity. They told us that where patients lacked capacity to make a specific decision that they involved families and advocates in making a best interest decision.

Most patients care and treatment records contained mental capacity assessments completed in relation to all aspects of care and treatment provided. Where patients' lacked capacity, there was evidence that staff had followed the best interests decision making process involving the relevant people. In one record, we found that a patient lacked capacity in all areas of their care and treatment, they had been prescribed a medication crushed. There was no mental capacity assessment or best interest decision recorded in relation to this. We raised this with the registered manager and the provider supplied evidence that this was completed after our inspection.

It was not clear how the service monitored adherence to the Mental Capacity Act. Audits in the Mental Capacity Act were not part of the hospital's audit schedule.

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	Requires improvement	Requires improvement	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate	Inadequate

Inadequate

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

Safety of the ward layout

Staff completed an annual risk assessment of the care environment including the risk of ligature anchor points. A ligature anchor point is something that someone can fix something to for the purpose of hanging or strangulation. The last ligature audit and risk assessment was completed in November 2018. This identified that all ligature anchor points were to be managed locally. There were no actions identified to reduce or remove ligature anchor points.

Although managers had entered the hospital's windows on the risk register because of safety concerns, they had not identified all the risks and there was insufficient action taken to manage risk. They had identified that the external frames had rotted, a secondary glazing was fitted but it could be removed from its runners with minimal force. A make shift secondary perspex glazing, which was below the expected standards, was used in some areas and there was no shatter film protection on windows vulnerable on the ground floor to prevent the windows from shattering if broken. We saw and raised concern that in three bedrooms, the cord of the blind was exposed and we were significantly concerned about the potential risk of hanging whether accidental or by intentional ligature. The registered manager told us that the blinds were fitted between an internal window and an external window and the internal window should only be open during the day when all patients had at least one to one staff observation. The registered manager also told us that they believed that the cord would snap if pressure was applied. A business case had been submitted for works to improve the windows in the service and was part of the estate's improvement plan. However, there was no date for this work to be completed.

Although the ward layout did not allow staff to observe all parts of the service, this was mitigated through enhanced patient observations and staff presence of the areas in use by patients. The service was laid out over three floors and had many rooms and corridors.

The service complied with guidance on eliminating mixed sex accommodation because it only provided care and treatment to male patients.

Staff had access to alarms and patients had easy access to nurse call alarms. All staff carried a mobile personal alarm which worked in the hospital and outside in the garden. Staff carried pagers that displayed the location where alarms had been activated so they could respond to provide assistance. Communal areas and patient bedrooms were fitted with a nurse call alarm panel. Patient bedroom doors were also fitted with a door sensor which would alert staff that the patient had opened their bedroom door during the night.

Maintenance, cleanliness and infection control

In April 2019 an external auditor had completed an infection control audit and action report. The areas for improvement identified were monitored through an action plan which the provider had marked as completed.

Although the environment appeared clean, three patient bedrooms, en-suites and the corridor had strong and unpleasant odours of damp and urine. We raised this in our

feedback at the end of our inspection and afterwards the provider confirmed that they had undertaken a deep clean of all patient bedrooms and corridors. They stated that further deep cleans were required to remove all the odours. Cleaning schedules indicated that the hospital undertook daily cleaning of all areas and deep cleaning of all areas monthly.

The communal areas had furniture in good condition. However, the environment was tired and worn in places with scuffs and damage to the walls. The clinic room environment was poor with units that were rusting at the bottom.

Staff did not always practice in line with safe food hygiene. During our inspection, on one day, the food that was on the menu for the evening meal was left out of the freezer and refrigerator in the morning at room temperature. We raised this with the registered manager who addressed this immediately. Staff explained this was an oversight.

The service had anti-bacterial hand gel situated around the hospital for people to use to promote infection control.

Seclusion room

The hospital did not have a seclusion room. Staff told us that they did not use seclusion.

Clinic room and equipment

Staff had easy access to resuscitation equipment including a defibrillator and adrenaline emergency medication. This was checked regularly. A ligature cutter was also available.

Staff maintained equipment. They had equipment to measure or test temperature, oxygen saturation levels, blood glucose monitoring, height, weight, blood pressure and urine. All equipment had asset stickers and was checked in line with manufacturer recommendations by an external company.

Examinations that required a patient to lay down were completed in patients' bedrooms because the clinic room did not have an examination couch.

A fabric chair was removed from the clinic room after we raised concern that this was soiled and it was made of fabric. This was not in line with good infection prevention and control practice.

Safe staffing

Nursing staff

There was not enough substantive staff and this meant that the hospital relied on bank and agency staff to make sure there was enough staff to provide safe patient care.

There was no flexibility in the nursing establishment level set. Although, the provider reported that they had appointed a registered nurse into the one registered nurse vacancy, the establishment level was only 6.55 whole time equivalent. With all the vacancies filled, this only just covered the amount of registered nurse shifts required to meet minimum staffing levels. Each day shift required two nurses and each night shift one registered nurse. If any nurses were off work due to annual leave or sickness, the hospital would have to rely on staff working additional hours, bank or agency.

The establishment for health care assistants was 53.7 whole time equivalent. The number of vacancies for health care assistant was 13 whole time equivalent which equated to a 24% vacancy rate. The provider had recruited two whole time equivalent support workers and two bank support workers who were awaiting their pre-employment checks and a start date.

From May 2018 to April 2019, the number of shifts filled by bank staff was 703 and the number of shifts filled by agency staff was 2,517. In total this equated to 24% of the total amount of shifts available. The number of shifts not filled during that period was four.

In the 12 months leading up to our inspection, the average staff sickness rate was 4% and the average staff turnover rate was high at 39%.

All patients had at least one to one staff support during the day and at night time. Some patients had two to three staff to support them during the day time. Managers ensured that there were enough support workers on shift to meet individual patient observation levels during the day and at night. In addition, during the day the hospital also had two registered nurses and two support workers and at night one registered nurse and one support worker in addition to the individual patient observation levels. During our inspection and rotas for the previous four weeks also confirmed that this level of staffing was maintained.

Managers could adjust the staffing levels to take into account the needs of the hospital.

The hospital used bank and agency staff. The hospital maintained a record of agency staff including a profile with

confirmation of a current disclosure and barring service check and the training they had completed. Agency staff received a 12-hour induction where they completed an induction checklist, read the priority policies including, safeguarding and whistleblowing and patients' care plans. Agency staff also completed some shadowing of regular staff. Due to the level of observations required in the service, agency staff were usually allocated to work with a regular member of staff as part of a two staff to one patient ratio or three staff to one patient ratio.

In the 12 months leading up to our inspection, there was no escorted leave cancelled due to staff shortages.

There were always enough staff to carry out physical interventions in the service.

Medical Staff

The hospital did always not have adequate medical cover. There were 1.5 whole time equivalent consultant psychiatrists in post, although, both consultant psychiatrists also had patients at one other service each nearby. The policy for out of hours medical cover did not state the time it would be expected for a doctor to attend the hospital in an emergency. It stated that the doctor on call would be expected to call back within 20 minutes and that the medical director would approve whether the doctor was located close enough to the hospital. This was a previous provider's policy and was not in line with national guidance on doctors being able to attend psychiatric emergencies promptly. Doctors told us that they did not attend the hospital in an emergency, they would expect the emergency services to attend.

Mandatory training

Although, the provider reported that 93% of staff had undertaken the various elements of training that they had set as mandatory, they had not trained any staff in immediate life support and the hospital used restrictive interventions. They provided staff with emergency first aid training which was up to a basic life support level standard with additional oxygen therapy training.

None of the provider's mandatory courses fell below the target of 80%.

Assessing and managing risk to patients and staff

Staff completed a risk assessment of every patient on admission and reviewed it regularly. Staff used a previous provider's risk assessment tool and nurses undertook a nursing assessment. The six patients' records reviewed contained a detailed risk assessment and risk management plan.

Management of patient risk

Staff undertook assessments to identify patients' risk of falls and used the Waterlow score to assess the risk of the development of pressure sores.

Staff identified and responded to changing risks to or posed by patients. They discussed changes in risk and incidents in handovers and daily flash meetings to ensure staff were aware of changes in risk. Flash meetings involved all staff and discussed key information about the day ahead.

Staff followed policies and procedures for the use of observation. All patients were allocated a minimum of one staff to one patient during the day. Our observations showed that staff maintained the level of observation assessed as appropriate for each patient.

Managers told us that staff only searched patients or their bedrooms where there was concern patients had items that may pose risk to themselves or others. They had a metal detector wand to use when searching.

There were inadequate systems and processes around restrictive practices. They did not have a formal governance process for identifying, approving or reviewing restrictions and blanket restrictions. There was no record of blanket restrictions in operation. Managers told us that the hospital had no blanket restrictions and the only restrictions applied were those expected for a mental health ward. For example, weapons, drugs and alcohol. However, we saw that there were areas of the hospital which were not accessible to patients, patients only had access to their phones, camera and tablets with staff supervision, patients did not have keys for their bedrooms and patients were routinely provided with plastic cups and plates. Managers told us that they could have ceramic crockery if they asked for these, however, patients had complex communication needs and it was unlikely they would ask for these. However, at the factual accuracy stage, the provider submitted documents completed in July 2019 that showed the provider had undertaken a review to identify blanket restrictions and had developed an action plan to try to reduce some of the restrictive practice. The provider also had appointed a reducing restrictive practice lead.

Six patients were routinely denied access to their own personal possessions. There was inadequate documentation to support why these restrictions were proportionate and the least restrictive option. We saw that these patients had bedrooms bare of the patient's personal effects and personalisation. One patient could only use the 'café' four times per day, their care and treatment records did not contain any information about this. The café was a room next to the dining room with a few seats and a worktop with flasks for patients to make hot drinks. When we raised this a care plan from 2018 was found electronically. Running out of café tickets had been a trigger for an incident occurring in May 2019. There was no evidence that this restriction had been reviewed since the care plan that was found from 2018. However, at the factual accuracy stage, the provider submitted documents completed in July 2019 which showed the provider had undertaken a review of the individual restrictions on each patient to identify whether these were proportionate and recorded appropriately in patients' records. An occupational therapist had also reviewed five patients' bedrooms to ensure that restrictions on access to personal belongings and personalisation was justified and proportionate.

The hospital permitted smoking in a designated smoking area in the garden.

A sign was displayed for informal patients to explain their right to leave the hospital at will. The hospital entrance was locked from the outside, but people inside could open the door to leave at any time using a thumb turn lock to exit.

Use of restrictive interventions

In the 12 months leading up to our inspection, the provider reported that there had been no incidents of seclusion. Staff and managers also confirmed that the hospital did not use seclusion. There had also been no incidents of long-term segregation or rapid tranqilisation used.

A comparison of the use of restraint at this location showed a substantial increase over time. In 2016, in the six-month leading up to our inspection in 2016 there had been 16 incidents of restraint on 12 patients. In 2018, in 12 months leading up to our inspection there had been 358 restraints on 13 patients. And between 1 April 2018 and 14 May 2019, there had been 1,069 incidents of restraint on 17 different patients. The provider reported that 570 of those were floor-based holds and 499 were non-floor based holds. None of these restraints were in the prone position. The hospital used the Maybo physical restraint model which did not teach prone restraint.

Staff received training in positive behavioural support and all patients had a positive behavioural support plan. This detailed action that staff should take to support patients positively and to de-escalate where patients displayed signs that they may becoming unsettled.

Although the service had a reducing restrictive practice strategy, it was not effective and there was no evidence this had been turned into tangible action. Statistics showed that the use of restraint was increasing significantly each year. The reducing restrictive practice strategy only related to use of restrictive interventions and not restrictive practice.

Safeguarding

Ninety one percent of staff were trained in safeguarding. Staff told us that they would report any safeguarding concerns, so these could be referred as a safeguarding alert.

In March 2019, there were safeguarding concerns raised by an external whistle blower, and following review of close circuit television, managers identified safeguarding concerns involving one member of staff and reported these to the local authority and the police. At the time of our inspection, that case was with the criminal prosecution service. The staff member involved had been dismissed by the provider.

Because of this incident, managers were reviewing close circuit television regularly and the hospital was ensuring that all registered nurses completed safeguarding level three training, and this would mean that there would be a named safeguarding lead on each shift. Team meeting minutes showed that managers encouraged staff to raise any concerns. The safeguarding policy was the policy of the month discussed in the staff team meeting and managers organised a visit from the provider's safeguarding lead for staff to meet and talk to.

We raised a safeguarding alert because two carers raised concerns about one patient having unexplained injuries and one carer raised concern about the same patient not

receiving appropriate medication attention following an injury. The provider told us after this they had completed some monitoring at Newbus Grange instead of taking the patient the hospital for treatment.

Staff followed safe procedures for children visiting the hospital. A separate entrance at the back of the hospital could be used and visits took place in a meeting room.

Staff access to essential information

A combination of paper and electronic patient records were used. Most of the patients' care and treatment records were paper-based and stored across four different files. These were an activity, multi-disciplinary team, care programme approach and Mental Health Act files. The hospital used an electronic incident reporting system. All staff apart from support workers had access to the incident reporting system. Support workers reported incidents by recording these in patients' paper records and nursing staff entered this onto the electronic system.

Medicines management

Medication in use was stored securely and registered nurses were the staff that held keys. Medication records were kept up to date. The provider had a process for medicines reconciliation. However, some medicines ready for disposal were in a box unlocked in the clinic room. When we raised this, staff locked these away.

One patient was at risk of harm because staff had not ensured they had followed the medication policy for administering medication off-license. One patient was prescribed one of their medications to be crushed and administered in a fruit juice or yoghurt. The policy, which was from the previous provider and overdue review from November 2017, stated that medicines prescribed off license must have an off-license protocol. There was no protocol in place. When we raised this with the doctor, they obtained an off-license protocol that outlined the crushed medication could have an anaesthetic effect on the tongue and to use with caution and take care with hot food. This information had not been available to staff and this meant that they may not have known to be aware of hot food after medication administration. The patients' care and treatment records did not contain a care plan or a risk assessment around this medication. There was no documentation to state why this medication treatment option had been selected and other medications within the same class discounted and there was no information for staff about the risk of not taking all the medication if the food or drink that the medication was mixed with was not all consumed.

Until we had raised concern, staff had not ensured that there was a legal authority to administer this medication to the patient. They had not considered whether this medication was covert and whether the patient had capacity to consent to taking this medication. This meant that they had had not undertaken a mental capacity assessment or a best interest decision making process around this decision. After our inspection, a mental capacity assessment had assessed the patient lacked capacity and a best interest decision was completed.

The hospital had signed up to the STOMP (Stop the overmedication of people with learning disabilities) pledge.

Track record on safety

There were 14 serious incidents in the 12 months leading up to our inspection.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. Incidents were recorded in patients running records. Registered staff had access to the electronic incident reporting system. Registered nurses responded to all incidents when mobile personal alarms had been activated. They reported incidents on the system and inputted any incidents that they had not witnessed word for word from patients' contemporaneous records.

Staff understood that when something went wrong that they should be open and transparent. Managers ensured that the duty of candour was carried out. Carers told us that they were informed of any incidents including restraint, safeguarding concerns or medication incidents by managers including action taken as a response.

Staff could not recall receiving feedback on investigations of incidents undertaken internal and external to the service. Team meeting minutes did not show that learning from incidents had been shared with staff.

Staff received debriefs and support following incidents. They also had access to the provider's employee assistance programme.

Inadequate

Wards for people with learning disabilities or autism

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Staff completed a comprehensive mental health, learning disability and autism assessment of the patient in a timely manner at, or soon after, admission. All admissions were planned and wherever possible doctors attended the service and tried to undertake a mental health examination. The first four weeks of admission were used as an initial assessment period by the multi-disciplinary team. The six records we reviewed in this area showed that staff completed mental health, learning disability and autism assessments.

Staff assessed patients' physical health needs in a timely manner after admission. All six records that we reviewed showed staff completed physical health assessments. All patients were registered with a GP and they visited the service to undertake physical health assessments after admission and annual health checks.

All patients had a range of care plans that outlined the care and treatment that the patient needed. Care plans were personalised and recovery-oriented. Each patient had their own individualised care plans. The care plans covered a range of areas that each patient needed support with. However, there were gaps in care planning in relation to crushed medication and for those who had limited or no personal possessions in their bedrooms. Staff reviewed care plans monthly or sooner if necessary.

All patients had a positive behavioural support plan in place.

All patients had a sensory assessment and a communication assessment which outlined their sensory needs and communication needs completed by occupational therapy and speech and language therapy. Additional communication resources were created to support patients with communication including communication keyrings that contained key personalised information.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. These included: access to psychological therapies, occupational therapy, speech and language therapy, physical exercise, recreational activities and medication.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. A GP visited the service and patients had access to other health professionals including podiatry, dentists and if required an optician. Where necessary, patients with specific medical conditions had care plans in place, for example, patients with epilepsy.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. Where appropriate, patients had been assessed for swallowing difficulties. Where patients had an underlying medical condition, care plans were in place so that staff understood how to make sure that the patient's needs were met. For example, a medical condition where the sodium levels in the blood can become too low.

Staff supported patients to live healthier lives. They provided patients with a balanced diet and encouraged patients to exercise. A sports co-ordinator had designed a range of activities suitable for patients to encourage them to exercise. Specific interventions were planned on an individual patient basis. For example, smoking cessation advice.

Staff used rating scales including the Health of Nations Outcome Scale for people with Learning Disabilities.

Staff participated in clinical audits in the following areas: health and safety, engagement and observation, care audit, infection control, physical healthcare, section 58 and 59 (of the Mental Health Act), deprivation of liberty safeguards, Mental Health Act, information governance, ligature assessment, safeguarding, suicide and close circuit television.

Skilled staff to deliver care

The team included or had access to the specialists required to meet the needs of patients. As well as doctors and nurses, the hospital had an occupational therapist and a consultant counselling psychologist. The occupational therapist and psychologist shared their time between this hospital and one other each in the local area. It was acknowledged that an increase in dedicated occupational

and psychology provision would be beneficial to patients as they would have more time to deliver therapies. The provider had a regional speech and language therapist that could be accessed when required.

Permanent registered nursing staff were experienced and had the right skills and knowledge to meet the needs of the patient group.

Managers provided permanent non-registered staff with an induction that consisted of an introduction to the organisation, person centred approach, learning disability awareness, communication, an introduction to autism and an introduction to positive behavioural support.

Managers ensured that staff had supervision. The percentage of staff that received regular supervision in the 12 months leading up to our inspection was 88%. Reflective practice sessions had started in line with the hospital's reducing restrictive practice strategy.

Managers ensured that staff had access to regular team meetings. Team meetings took place monthly and minutes were produced for staff who did not attend to read. Each team meeting, a policy of the month was chosen and discussed with staff.

The percentage of staff who had an appraisal in the 12 months leading up to our inspection was 96%.

Permanent staff had access to further specialist training for their roles. This included training in different communication methods including: picture exchange communication system, Makaton and British Sign Language. Staff also had access to training in the SPELL and TEACCH frameworks and approaches for understanding and responding to the needs of people with autism from the National Autistic Society. The SPELL framework stands for structure, positive, empathy, low arousal, and links, and TEACHH approach stands for teaching, expanding, appreciating, collaborating and cooperating and holistic. However, this training was not mandatory, and the service did not provide information about the number of support workers that had taken up these opportunities except for British Sign Language which one member of staff had completed.

Staff had access to undertake the diploma in Health and Social Care levels two and three through an external training provider. The hospital also worked closely with an external training provider that provided the following courses for staff: understanding Autism, mental health problems, safe handling of medications, care planning, infection control, behaviours that challenge, customer service, cleaning principles, team leading and business administration. However, this training was also not mandatory and the service did not provide information about the number of support workers that had taken up these opportunities. At the factual accuracy stage, the provider told us that 47% of the support workers had a level 2 or 3 certificate in Health & Care, 5% were undertaking this certificate and 34% had the Care Certificate.

Our observations were characterised with a failure to engage and initiate interactions. In the observations we undertook 16 out of the 33 frames showed poor or negative interactions with patients.

Managers identified poor staff performance and raised this to address with staff. Staff files contained evidence that managers had addressed performance issues with individual staff appropriately. This included allegations around the use of a non-approved physical intervention, two staff found sleeping whilst on duty and one staff not fulfilling a responsibility to provide staff with supervision. Staff conduct was also discussed in detail generally with all staff in the March 2019 team meeting. Specific concerns were raised that included staff swearing whilst on duty, not always following the dress code, not always initiating interactions with patients, staff 'social gatherings' on shift, staff not ensuring that they carry out their responsibilities and not always considering patients' or visitors' needs.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multi-disciplinary team meetings. The multi-disciplinary team meet weekly to review patients' progress in their care and treatment. In the first four weeks of admission, the team reviewed the patient weekly and after four weeks, the patient was reviewed once every four weeks. Each patient had a care programme approach meeting every six months.

Staff shared information about patients at effective handover meetings within the team. There was a shift to shift handover and each morning a flash meeting took place attended by all staff available to plan the day and discuss any pertinent information.

Staff had effective working relationships, including good handovers, with other relevant teams outside of the organisation. That included care co-ordinators and commissioners, health professionals, advocacy and the local authority safeguarding team.

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

Ninety one percent of staff had training in the Mental Health Act. Staff were trained in and understood the Mental Health Act, the Code of Practice and the guiding principles.

Staff had access to administrative support on the Mental Health Act and its code of practice. The hospital had its own administrators responsible for the Mental Health Act

Staff had access to the Mental Health Act policy and procedure which was available in the nurses' office.

Patients had access to information about mental health advocacy. This was displayed in an easy to read format in a notice board in the hospital's entrance hallway. Advocates also visited the service regularly and were invited to attend multi-disciplinary meetings.

Staff explained detained patients their rights in accordance with section 132 the Mental Health Act, they undertook this monthly and recorded when this had been completed and the outcome in patients' Mental Health Act files. Staff used easy read literature when explaining rights to patients.

Staff ensured that detained patients were able to take section 17 leave (permission granted for patients to leave hospital). Care and treatment records contained a section 17 leave form which outlined the conditions for the patient's leave directed from their responsible clinician.

Staff requested an opinion from a second opinion appointed doctor when necessary. Detained patients' records contained capacity to consent to treatment assessment and valid certificates of consent. Relevant records contained a T3 certificate. A T3 certificate is issued by a second opinion appointed doctor appointed by the CQC where a detained patient cannot or will not consent to treatment. The second opinion appointed doctor reviews patients' circumstances including their views and the clinical appropriateness of the treatment before issuing a T3 certificate.

Staff stored copies of patients' detention papers and other associated records including section 17 leave forms and records on rights in accordance with section 132 in the patients' paper based Mental Health Act file.

The service displayed a notice to tell any informal patients that they could leave the ward freely. The front door to the hospital could be opened from the inside without a key or a code required.

Audits in the Mental Health Act were part of the hospital's audit schedule. These took place every six months and staff submitted centrally to the provider and the quality assurance manager.

Good practice in applying the Mental Capacity Act

Ninety three percent of staff had received training in the Mental Capacity Act. Staff had a sound understanding of the Mental Capacity Act but they did not always apply this.

There were two deprivation of liberty safeguards applications and authorisations made in the 12 months leading up to our inspection to protect people without capacity to make decision about their own care. This was in line with the number of patients who were subject to deprivation of liberty safeguarding authorisations at the time of our inspection at the hospital.

Staff had access to a copy of the policy on the Mental Capacity Act and deprivation of liberty safeguards which was kept in the nurses' office.

Staff could seek advice from their colleagues on the Mental Capacity Act and the deprivation of liberty safeguards.

Staff told us that they gave patients every possible assistance to make decisions for themselves before they assessed patients' capacity. They told us that where patients lacked capacity to make a specific decision that they involved families and advocates in making a best interest decision.

Most patients' care and treatment records contained mental capacity assessments completed in relation to all aspects of care and treatment provided. Where patients' lacked capacity, there was evidence that staff had followed the best interests decision making process involving the relevant people. In one record, we identified that this had

not been completed in relation to a medication prescribed. However, we raised this with the registered manager and received evidence that this was completed after our inspection.

It was not clear how the service monitored adherence to the Mental Capacity Act because audits in the Mental Capacity Act were not part of the hospital's audit schedule.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

During our inspection we undertook six observations of patient and staff interactions and seven SOFIs (short observational framework for inspection). We also spoke with two patients.

In our observations and SOFIs we measured that 16 out of 33 frames of time that staff had poor or negative interactions with patients. Of the 16 observed, 10 frames were poor with patients repeating themselves multiple times before staff acknowledged or responded to their communication. Six of the frames were neutral where staff did not initiate any interaction or activity with the patient when supporting them. The remaining frames showed appropriate interactions.

Staff supported patients to understand and manage their care, treatment and condition through creating easy to read material based on their communication assessments and care plans.

The two patients that we spoke with told us they liked it at Newbus Grange and they liked the staff. Two carers told us that they had raised concerns about staff in the past. They told us that they did not feel staff had interacted with a patient enough or inappropriately which may have been a trigger for them becoming distressed. One carer told us that they had seen a member of staff asleep on duty. Two carers raised concerns about unexplained injuries to one patient and one of these carers also raised concern that staff had not sought appropriate medical attention following an injury to the same patient. We raised those concerns as a safeguarding alert. The provider told us after this they had completed some monitoring at Newbus Grange instead of taking the patient the hospital for treatment.

Staff understood the individual needs of patients and tailored the support they provided to reflect this. We saw some individualised and appropriate interactions between staff and patients.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviours or attitudes towards patients.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orientate patients to the service. The service had an easy read brochure that explained information to patients about what to expect when staying at Newbus Grange. The brochure contained photographs of different areas so patients could see where there would be staying. Patients were always allocated at least one to one staffing during the day and so had staff that could support their orientation to the hospital on their admission.

Staff involved patients in care planning and risk assessment as much as possible. Patients had complex needs and communication difficulties. Where it was difficult to obtain patients' views, staff had involved carers, advocates, care coordinators and asked for information from previous providers.

Staff communicated with patients to try and support them to understand their care and treatment by explaining things and using communication resources to involve patients.

Staff enabled patients to give feedback on the service they received. In 2018, a service user satisfaction survey was completed. Staff used an observation questionnaire, pictorial questionnaire and talking mats. There were no actions identified from this survey. Staff supported patients to give feedback by completing an easy read form. Completed forms were discussed in staff team meetings.

Two patients were involved in the people's parliament run by the provider.

Staff ensured that patients could access advocacy. An advocate visited the hospital regularly. Advocates were

involved in multi-disciplinary team meeting reviews about patients' care and treatment. They were also involved in care planning and in best interest decisions made for patients' that lacked capacity to make specific decisions.

Involvement of carers

We received feedback on the service from seven carers. Staff informed and involved families and carers appropriately and provided them with support when needed. Carers told us that staff made arrangements so that they could see patients regularly and staff would support patients to go out with their families. Carers told us that they received important information about patients' care including when incidents had occurred, any safeguarding concerns and when something went wrong. Carers told us they were confident that managers were open and honest and acted to address any concerns raised. Carers were invited to attend meetings about patients' care and treatment.

Staff enabled families and carers to give feedback on the service they received. Carers felt confident in speaking to staff and managers about their views and any concerns. In the 12 months leading up to our inspection, the hospital had received five compliments from families and carers.

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

Inadequate

Access and discharge

Bed management

The hospital provided assessment, care and treatment for patients with a diagnosis of autism and learning disabilities with associated complex needs. It admitted patients from across the country. At the time of our inspection, the hospital had a 59% occupancy rate.

There was always a bed available when patients returned from leave as admissions and discharges were planned carefully due to the complex needs of patients. Patient discharges were planned carefully by the multi-disciplinary team to ensure this happened at a time which would be in the best interests of the patient with the appropriate discharge package of care and support.

Patients were not moved between locations during an admission episode unless this was justified on clinical grounds and in the best interests of the patient.

The current patients' length of stay varied from 11 months to eight years. One patient was working towards discharge to a community placement.

The hospital did not provide psychiatric intensive care services. If a patient required more intensive care, then they would require a transfer to another hospital who could provide this level of care.

Discharges and transfers of care

In the 12 months leading up to our inspection, there were three delayed discharges. However, the reason for these delayed discharges was that there were insufficient community-based placements available that would meet the needs of the patients.

Staff planned for patients' discharge including good liaison with care managers and care co-ordinators. They worked actively with commissioners to plan and facilitate discharges. All patients had Care and Treatment Reviews in line with NHS England's commitment to transforming services for people with learning disabilities, autism or both.

Patients ready for discharge had a transitional discharge plan. During our inspection, one patient was four weeks away from discharge, a community adult social care provider was increasing their transitional support into Newbus Grange each week for a 12-week period. Both providers were working closely together to try and make discharge process as positive and consistent for the patient as possible.

Staff supported patients who required treatment in an acute hospital. They created detailed plans to ensure that all the relevant arrangements were made with named professionals at the acute hospital to reduce any distress for the patients.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own en-suite bedrooms and they could access these at any time of day.

Patients' privacy and dignity was not a sufficient priority. Two patients' bedrooms did not have any curtains or blinds; only one of the bedrooms was fitted with a frosted film to the window. This meant that they did not have complete privacy and could not restrict natural light. We were also concerned that this would affect patients' orientation to time and sleep with lighter nights and morning.

Staff routinely denied six patients access to their personal possessions. This meant that patient bedrooms varied in personalisation. At the time of our inspection, there were ten patients at the hospital. Six out of ten patient bedrooms were bare, stark and had limited or no personal belongings. We raised this during our inspection and the registered manager told us that this was due to patients' needs. However, there was little or no information in patients' records to explain why this was proportionate or the least restrictive option. There had been no individual assessment of the of the risks posed to individual patients. The four other patient bedrooms in use were more personalised and contained more personal belongings. However, at the factual accuracy stage, the provider submitted documents to showed in July 2019 that an occupational therapist had undertaken a review of five patients in relation to their bedrooms, personalisation and access to personal belongings to try to address these issues.

Patients had somewhere to secure their possessions. Staff held the keys for patient bedrooms and these could be locked, and most patient bedrooms had lockable furniture.

Staff and patients had access to the full range of rooms to support treatment and care. The hospital had a range of rooms that could be used for therapies, arts and crafts and recreation. For some patients, bedrooms vacant adjacent to their bedrooms had been turned into the patients own lounge.

There were quiet areas of the ward and a room where patients could meet visitors. A side entrance at the hospital could be used and patients could meet visitors in a meeting room. We also saw that some patients had visitors in their bedroom or could spend time with them in their own lounge and some patients were supported to go out with their carers. This was dependent on individual patients' needs.

Most patients needed support to make calls and we saw that staff facilitated them to video call their families. The hospital also had a phone that patients could use if they did not have their own.

Patients had access to outside space. The hospital was set in large grounds that included a sensory garden and an allotment. There was also sports equipment to play games, bicycles and tricycles.

The food was of a good quality. The hospital had chefs and a four-week rolling menu. Patients were given the choice of the two dishes prepared at each meal time to choose from. Any special dietary requirements could be catered for including allergies and swallowing difficulties.

Patients could make hot drinks and snacks 24/7. The dining rooms had orange and blackcurrant cordials that could be accessed at any time. In between meals, a café with flasks was available and patients could make hot drinks with staff support. Patients could also access a therapy kitchen with staff to make snacks or drinks. Fruit was available throughout the day in the dining room or café lounge.

Patients' engagement with the wider community

Staff supported patients to maintain contact with their families and carers. They invited them to be involved in meetings about their care and treatment and facilitated visits at the hospital and the local area.

Staff encouraged patients to develop and maintain relationships with people that mattered to them. Staff supported patients to access amenities in the local area. Over time, the hospital had developed a rapport with the local community. They attended local events and had donated a Christmas tree which was displayed in the community.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients for example, by ensuring disable people's access to the premises. Although, the hospital was a listed building,

some adaptions had been made to make this more accessible for disabled people. This included, ramps and lifts which meant that there was step free access. Some of the bedrooms had wet rooms which were more accessible.

Patients had an individualised activity plan with activities throughout the day seven days per week. An activities co-ordinator organised activities and patients had funds available to spend on activities outside of the hospital.

Not all patients had a full communication assessment and care plan. Some patient records contained a communication assessment and care plan which outlined their communication needs. Patients' had access to easy read documents created to facilitate their understanding of their care and treatment records.

Information was displayed in easy read formats around the hospital, so patients could understand their rights to complain, to contact the CQC and speak to advocacy services.

The food menu was written in very in very small text and were not easy to read for anyone especially for patients who may have difficulty with reading and understanding.

Where required, staff could make information leaflets available in different languages.

Staff and patients had access to materials and training to meet the communication needs of patients. This included training in voice output communication aids, Makaton and British Sign Language. However, the service did not provide details on how many staff had completed this training except for British Sign Language which one staff member had completed.

The hospital had chefs who could prepare foods to meet the dietary requirements of religious and ethnic groups.

Staff would ensure that patients had access to appropriate spiritual support on an individual patient basis.

Listening to and learning from concerns and complaints

The hospital received five complaints in the 12 months leading up to our inspection. Of these, three complaints were upheld, one was partially upheld and one was not upheld. None of these complaints were referred to the parliamentary health service ombudsman.

Due to patients' complex needs and vulnerabilities, they could not always complain or raise concerns. Patients' carers told us that they raised any concerns or complaints on behalf of their relatives and they were satisfied with the action taken to resolve their concern or complaint.

Staff were encouraged to raise any concerns to managers as it was recognised that the patient group was vulnerable and may not be able to tell others if they had concerns or complaints. The hospital also had regular visits from advocates and commissioners who could raise concerns or complaints on behalf of patients.

In the 12 months leading up to our inspection, the hospital had received 30 compliments.

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

Inadequate

Leadership

The hospital's manager, who was the registered manager, had been appointed as the regional manager in January 2019 and since then was undertaking both the regional manager role and the hospital and registered manager role. This meant that they had not been spending as much dedicated time at this hospital. A new hospital manager had been recruited but had not yet started in post. The hospital also had a deputy manager.

Leaders had a good understanding of the services they managed, staff and carers told us they were visible in the service and approachable for patients and staff. The deputy manager was based at the service. They knew patients and their individual needs well and had developed positive relationships with carers and families. Staff told us that leaders were approachable and supportive.

Leadership development opportunities were available, including opportunities for staff below team manager level. The hospital's manager had progressed into a regional manager position. There were leadership opportunities for registered and non-registered staff with senior roles such as charge nurse and senior support worker positions. Staff also took on additional responsibilities by taking on lead roles in the hospital. Staff could also access additional training that was relevant to their roles.

Inadequate

Wards for people with learning disabilities or autism

Vision and strategy

Staff were not clear what the current vision and values were. Although, Cygnet had purchased the hospital in August 2018, there had been a slow process and limited rebranding of the hospital or implementation of Cygnet's policies and operating procedures. At the time of our inspection, all the policies and paperwork in use were from a previous provider. We met with Cygnet's regional clinical and therapy leads, and they told us that they had a plan for change in the hospital to bring the hospital into line with other similar services owned by the group. They told us this needed to be co-ordinated to ensure consistency and limit any disruption.

Staff had the opportunity to discuss changes and bring forward their ideas to develop the service at a local level in staff team meetings.

Culture

Staff felt respected, supported and valued by their managers and the staff team. Staff felt positive and proud about working at Newbus Grange. Although they acknowledged that senior leaders from Cygnet had visited the hospital regularly, they did not feel part of the Cygnet group yet because they had seen slow and little change since Cygnet had taken over the hospital.

Managers had raised issues about poor staff performance in the staff team in the March 2019 team meeting after reviewing hours of close circuit television which identified issues with staff conduct and practices which were below the standards expected. There had also been individual staff performance issues that had been addressed with staff. Some staff were no longer working in the service because of these concerns and one member of staff had been charged with a criminal offence.

Staff knew how to raise concerns. They knew there was a policy on whistleblowing and how they could use this if needed. However, one member of staff told us that there was a 'zero tolerance to wrong doing' culture and we also found cases where individual staff had been dismissed by the provider. Although the provider had acted appropriately in these circumstances, this perception was a concern because staff may be afraid and reluctant to raise concerns in a culture where they did not think there was a fair and just response.

Staff received appraisals and could discuss career development and their development needs.

Staff reported that the provider promoted equality and diversity. All staff received mandatory training in equality and diversity.

Staff had access to support for their own physical and emotional health needs through an occupational health and well-being service. This had been promoted by senior leaders following concerns in another location so that staff could access support if they needed this. The service also had HR clinics for staff to speak with the provider's human resources department following being acquired by Cygnet. The average sickness rate was 4%.

Cygnet had sent registered nurses a card on international nurses' day to thank them for their service. Staff told us that they felt appreciated by this gesture.

Governance

We identified some issues in our inspection which had not been identified or addressed by the provider. This included inconsistent adherence to good infection prevention and control practices and staff not always ensuring the essential documents were in place to make sure that the administration was safe and administered with the right legal authority.

The hospital had inadequate governance of restrictions including identifying, approving and reviewing restrictions and blanket restrictions. Blanket restrictions implemented had not been recognised. There was no record of restrictions and no system to identify and approve restrictions. Restrictions implemented were not reviewed. As well as blanket restrictions in operations, six patients were routinely denied access to their own personal possessions and it was not clear why this was proportionate or the least restrictive. There were no individual assessments of the risks posed to patients. However, at the factual accuracy stage, the provider submitted documents completed in July 2019 that showed they had started to implement governance systems to identify, review and reduce individual and blanket restrictions that were in operation.

Although Cygnet had taken over the hospital in August 2018, the hospital continued to follow the previous provider's policies and procedures. Some of these were overdue for review including the template to assess

environmental risks and the medication policy. This meant that these may not reflect the most current best practice guidance. The on-call policy did not reflect national guidance on response times for doctors in relation to psychiatric emergencies.

However, systems and processes had ensured that the hospital filled shifts to make sure there was enough staff, that staff received training, staff had access to team meetings, supervision and appraisal. Discharges were planned and staff met the needs of patients using approaches including positive behavioural support.

The last three team meetings had consisted of two extraordinary meetings where managers focussed on key topics and a team meeting that followed a structured agenda to ensure that staff received pertinent information. Clinical governance meetings followed a standard agenda.

Staff participated in clinical audits prescribed in the audit programme. Staff acted upon the results of audits and created action plans to address any areas that required improvement although these were not robust as they had not identified and addressed the issues we found during our inspection.

Staff understood the arrangements for working with other teams internal and external to the provider to meet the needs of patients.

Management of risk, issues and performance

The hospital had a risk register. There were two items on the risk register and these related to a serious safeguarding concern which was under police investigation and safety risks of the windows in the service. These concerns matched the concerns of managers.

Although windows had been placed on the hospital's risk register, the risks identified did not fully reflect all the risks we identified. The risk register recorded the following as risks: external rotten frames, secondary glazing that could be removed from its runners with minimal force, make shift secondary perspex glazing used in some areas which was below expected standards and no shatter film protection on windows vulnerable on the ground floor. The risk register did not consider the potential risks of exposed blind cords and the privacy and dignity issues for the two patients' bedrooms that did not have blinds or curtains.

Staff could raise concerns for discussion and managers would consider concerns to be entered onto the risk register.

The service had a business continuity management plan in place to inform staff about procedures to following in the case of emergencies including damage to the hospital, loss of vital communications and utilities, adverse weather and outbreaks.

Information management

The service used mainly paper based systems. Staff and managers did not report any concerns that data collection was time consuming for frontline staff.

Senior leaders told us that there would be improvements made in information management through the introduction of an electronic patient care record system that all staff would have access to.

The hospital had information governance procedures in place and staff received training in data protection. Staff stored patient records securely.

Managers had access to information to support them in their management role. They received information on the performance of the service, staffing and patient care.

Staff made notifications to external bodies as needed.

Engagement

Staff, patients and carers had access to information about the provider. They received information about things that may affect them. For example, the regional manager had spoken to carers about media interest in another hospital following concerns.

Patients had opportunities to give feedback on the service they received in ways that reflected their individual needs. This included methods using assistive technology to communicate and observation to gather patient views.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. Managers were receptive to feedback and used this to make positive changes, they implemented a 'you said, we did board' to reflect how they had made changes following feedback from staff.

Inadequate

Wards for people with learning disabilities or autism

Patients and staff could meet with members of the provider's leadership team. During our inspection, senior leaders were undertaking a service review and they were engaging with staff and patients.

Leaders engaged with external stakeholders including commissioners.

Learning, continuous improvement and innovation

The hospital was accredited by the Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services in 2017. The hospital is accredited until 2020. The hospital was also achieved Autism accreditation with the National Autistic Society in 2017. This accreditation was valid until 2020.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that effective systems and processes are in place to assess and improve the quality and safety of the service.
- The provider must ensure that that its own policies and procedures are in use and that policies in use are reviewed to ensure that they are up to date with best practice and national guidance.
- The provider must ensure that action is taken to assess, manage and mitigate the risks to the safety of patients from the condition of the windows and the cords on the blinds.
- The provider must ensure that all areas are odour free.
- The provider must ensure that a doctor can attend the hospital promptly in the event of a psychiatric emergency.
- The provider must ensure that there are robust governance processes and records maintained to identify, authorise and review any type of restriction in operation.
- The provider must ensure that patients' care and treatment records contain information about any restrictions and a rationale about why this is proportionate and, in the patient's, best interests.
- The provider must ensure that staff follow policies in relation to medication. Patients should have a care plan and risk assessment for medications that are prescribed off license or could be considered covert medication.
- The provider must ensure that staff complete mental capacity assessments and best interest decisions where appropriate.
- The provider must ensure that all bedrooms have curtains or blinds to uphold privacy and to enable the restriction of natural light.
- The provider must ensure that clinical staff receive immediate life support training.

Action the provider SHOULD take to improve

- The provider should ensure that the hospital is well-maintained.
- The provider should reduce the use of agency staff.
- The provider should consider reviewing the dedicated occupational therapy, speech and language therapy and psychology input into the hospital to ensure this is sufficient.
- The provider should introduce an audit of care and treatment provided to ensure this caring.
- The provider should ensure that food menus are easy to read.
- The provider should ensure staff understand what the provider's vision and values are.
- The provider should ensure that staff follow safe food hygiene practices.
- The provider should ensure that all patients have a communication assessment and communication care plan completed.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not met: The provider had not ensured that all patients had privacy and dignity in their own bedrooms.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not met: At the time of inspection, staff had not carried out a mental capacity assessment or best interest decision for a medicine prescribed to be crushed.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not met: Staff had not ensured that there was an off license protocol in place for a medication prescribed to be crushed. This was not in line with the medication policy. There was no care plan or risk assessment in place for a medication prescribed to be crushed and staff did not have information about potential risks to the patient.

This section is primarily information for the provider

Enforcement actions

The medication policy had not set response time for a doctor to attend in an emergency. This was not in line with national guidance.

There were safety risks to some patients in their bedrooms from blind cords and the risk had not been managed or mitigated sufficiently by the provider.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not met: Blanket restrictions and individual patient restrictions were in operation. There was limited information to explain why restrictions were proportionate or necessary.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not met: There were issues with the maintenance and cleanliness of the hospital including unpleasant odours.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not met: The provider had ineffective systems and processes to identify, authorise and review individual patient and blanket restrictions.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not met: We identified issues with missing information all of the seven staff files that we reviewed.

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 How the regulation was not met: Not all staff received regular supervision.