Cygnet Yew Trees

Quality Report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services caring?	
Are services well-led?	Inadequate

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.

Edward Baker
Chief Inspector of Hospitals

Overall summary

We rated Cygnet Yew Trees as Inadequate because:

- The provider had not ensured consistent robust leadership and governance at the hospital since our last inspection. We identified risks for the service regarding incident reporting, incident investigation and learning and staff management of patient risks.
- Staff did not always know what incidents to report or when to report them. We reviewed 15 incidents documented in the daily case notes of three patients. We found four incidents that staff had not reported on the incident reporting system. Staff were not always aware of how to deal with specific risk issues such as choking. We found evidence of a patient twice choking on the same day despite their risk assessment highlighting a choking risk.
- Staff did not always follow the provider's policy for observing patients. Staff did not always respond to changes in patient's risk levels. We found evidence of staff not responding to a patient's changing risk following an incident of using a ligature. Staff did not follow the patient's observation plan after the incident and left the patient's door closed at night despite the patient being on continuous staff observation within eyesight. The provider identified another occasion when staff were sitting outside the patient's bedroom with the door shut and were not observing them as prescribed. Staff also left the patient unobserved whilst they responded to an emergency. We reviewed the observation records for three patients and found incidences where staff had remained on continuous observations for more than two hours. This was not in accordance with the provider's policy or protocol for enhanced observations of patients.
- Two patients told us they were not always directly involved in their care. One patient told us staff wrote the care plans and they would then tell the staff whether they agreed or not.
- There was not a clear framework of what staff must discuss at a ward or team meetings to ensure senior staff shared essential information. We reviewed the minutes for three team meetings. We could not see any evidence that staff had discussed incidents or complaints.
- Staff did not always make notifications to external bodies. We found evidence where four notifiable incidents had occurred, however staff had not made the necessary notifications to the Care Quality Commission. We also found evidence where staff had not informed the local authority regarding two safeguarding incidents, where patients had been the victim of assault by other patients.
- The environment was not purpose built and there was insufficient space to meet the individual needs of current patients. There was a high number of staff to meet the levels of observations required to manage the current patient group which made the environment crowded.

However:

Summary of findings

- The provider had appointed a new hospital manager, deputy manager and regional manager. Managers were aware of areas for improvement and had implemented plans to make these necessary improvements.
- Staff felt respected and valued by the senior staff. Staff we spoke to told us the morale within the hospital had improved over recent months and they spoke positively about the recent changes of leadership.

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** 	See below for details

Summary of findings

Contents

Inadequate

Cygnet Yew Trees

Services we looked at

Wards for people with learning disabilities or autism;

Summary of this inspection

Background to Cygnet Yew Trees

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

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

• Treatment of disease, disorder or injury.

The location does not have a registered manager. The provider had recently appointed a new manager who had applied to Care Quality Commission for registered manager status. The manager will also act as Controlled Drugs Accountable Officer.

The Care Quality Commission last carried out a comprehensive inspection of this service on 30 April 2019 and was in breach of regulation 12 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to:

- The provider's governance systems did not give sufficient assessment, management and mitigation of risks for the hospital.
- The provider had not ensured staff always recorded their observation checks of patients.
- The provider had not ensured sufficient checks of agency staff had taken place to ensure they were safe to work with patients.
- The provider had not ensured staff had clear information (such as protection plans) detailing care and treatment they should give to safeguarding patients following safeguarding incidents.
- The provider had not ensured their safeguarding policy reflected agency staff checks, staff training required, and protection plans.

At this inspection we found the provider had made some improvements but we continued to find breaches of regulation 12 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspection team

Our team consisted of two inspectors and one specialist advisor with experience of working with people with learning disabilities and autism.

Why we carried out this inspection

We carried out an unannounced focussed inspection of this service due to concerns around the use of restrictive interventions.

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?

Summary of this inspection

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

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the provider
- spoke with the interim manager and deputy manager
- spoke with eight other staff members; including doctors, nurses, support workers, therapy assistant, assistant psychologist and social worker
- attended one hand-over meeting
- Looked at four care and treatment records of patients
- carried out a specific check of the medication management on the wards and
- looked at a range of policies, procedures and other documents relating to the running of the service.

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:

- Staff did not maintain patient safety, or comply with the provider's observation policy, when completing enhanced level observations. Staff did not always respond to changes in patients' risk levels. We found evidence of staff not responding to a patient's changing risk following an incident of using a ligature. Staff did not follow the patient's observation plan after the incident and left the patient's door closed at night despite the patient being on continuous staff observation within eyesight. The provider identified another occasion when staff were sitting outside the patient's bedroom with the door shut and were not observing them as per their care plan. They also left the patient unobserved whilst they responded to an emergency.
- Staff remained on enhanced observations for extended periods of time. This was against the provider's policy and protocol. We reviewed the observation records for three patients and found incidences where staff had remained on continuous observations for more than two hours.
- Staff were not always aware of how to deal with specific risk issues such as choking. We found evidence of a patient twice choked on the same day despite their risk assessment stating the risk of choking.
- Staff had not always reported incidents of patients being the target for assault by other patients and as such, staff had not made the necessary safeguarding referrals to the local authority safeguarding board.
- Staff did not always know what incidents to report or when to report them. We reviewed 15 incidents documented in the daily case notes of three patients. We found four incidents that staff had not reported on the incident reporting system.
- Staff did not receive feedback from investigations into incidents and senior staff did not routinely share lessons learned. We reviewed team meeting minutes for the past three months and could not see evidence that staff discussed incidents.
- The environment was not purpose built and there was insufficient space to meet the individual needs of current patients.There was a high number of staff to meet the levels of observations required to manage the current patient group which made the environment crowded.

However:

Summary of this inspection

- Staff completed regular risk assessments of the care environment. We reviewed the environmental risk assessment which included a ligature risk assessment. This detailed all identifiable risks and actions staff should take to mitigate such risks. The provider had enough nursing and medical staff. The provider block booked agency staff to cover staff vacancies and provide continuity.

Are services caring?

We did not rate caring:

- Staff's attitudes and behaviours when interacting with patients showed they were kind caring and compassionate.
- Staff found effective ways to communicate with patients with communication difficulties. We saw staff using Makaton aids to communicate with a patient with hearing loss. We saw staff using sign language and Makaton to communicate with patients and staff using pictures boards to explain the day's activities and to help them choose what they would like for lunch.
- Patients could give feedback on the service they received. We saw minutes from community meetings where patients had given feedback on the menu and activity programme.

However:

- Two patients told us they were not always directly involved in their care. One patient told us staff wrote the care plans and they would then tell the staff whether they agreed or not.

Are services well-led?

Inadequate

We rated well-led as Inadequate because:

- The provider had not ensured consistent robust leadership and governance at the hospital since our last inspection. We identified risks for the provider regarding incident reporting, incident investigation and learning and staff management of patient risks.
- There was not a clear framework for staff discussions at a ward or team meetings to ensure senior staff shared essential information. We reviewed the minutes of three months of team meetings. We could not see any evidence that staff had discussed incidents or complaints.
- Staff did not always make notifications to external bodies. We found evidence where four notifiable incidents had occurred, however staff had not made the necessary notifications to the

Summary of this inspection

Care Quality Commission. We also found evidence where staff had not informed the local authority regarding two safeguarding incidents, where patients had been the victim of assault by other patients.

- The provider did not have a process in place to audit and monitor patient observation records. The provider had not identified that staff were not following their policy of not being on observations for more that two hours without a change of activity.

However:

- The provider had appointed a new hospital manager, deputy manager and regional manager with the aim of improving the service. Managers were aware of areas for improvement and had started to make improvements.
- Staff felt respected and valued by the senior staff. Staff we spoke to told us that the morale within the hospital had improved over recent months and they spoke positively about the recent changes of leadership.

Detailed findings from this inspection

Inadequate

Wards for people with learning disabilities or autism

Safe	Inadequate
Caring	
Well-led	Inadequate

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

- The environment was not purpose built and there was insufficient space to meet the individual needs of current patients. There was a high number of staff to meet the levels of observations required to manage the current patient group which made the environment crowded.
- The ward layout did not allow staff to observe all parts of the ward. There was closed circuit television which helped mitigate some of the risks of blind spots, however, there were still areas of the ward not covered by closed circuit television. Staff maintained enhanced level observations for patients who posed a risk to themselves or others. Senior staff had identified this and had plans to install five extra cameras to reduce the risk of blind spots. We reviewed the provider's maintenance action plan and saw that the provider was waiting for contractors to agree a date to come and fit cameras.
- Staff completed regular risk assessments of the care environment. We reviewed the environmental risk assessment which included a ligature risk assessment. This detailed all identifiable risks and actions staff should take to mitigate such risks.
- The provider only admitted female patients, therefore they were compliant with the Department of Health guidance on eliminating mixed sex accommodation.
- Staff had access to alarms and were able to call for assistance when necessary. The provider used to pinpoint alarm system and there were display units throughout the hospital to identify where the alarm had been activated.
- The environment was clean, well furnished, well equipped and some areas were well maintained. However, some areas, such as the lounge and dining room needed redecoration. We reviewed the provider's maintenance log and saw there were plans to redevelop the lounge area and introduce a sensory room. There were also plans for ongoing redecoration throughout the service.
- The clinic room was fully equipped and there was accessible resuscitation equipment in the staff office. We checked the records and saw that staff checked the equipment regularly.

Safe staffing

- The provider had enough nursing and medical staff to provide safe care and treatment for patients. There were four vacancies for qualified staff, however the provider had four block booked agency staff to cover these vacancies and provide continuity. The manager was looking at current baseline staff numbers and had recently increased the number of qualified nurses on each shift due to the recent high acuity of patients.
- The number of staff on each shift matched the provider's base line numbers. The provider was running on significantly higher levels of staff due to the number of patients on increased levels of therapeutic observations. However, this made the environment very crowded.
- The provider used regular bank and agency staff where possible. We reviewed the duty rotas for four weeks and saw that regular agency staff were block booked. We reviewed the staff files for three agency staff and saw that they had received an induction and that their training was up to date.
- There were enough staff to carry out physical interventions such as therapeutic observations and restraint. The provider increased staffing numbers to manage the higher levels on observations.

Assessing and managing risk to patients and staff

- Staff did not always respond to changes in patients' risk levels to ensure patient safety. For example, we found evidence of staff not responding to a patient's changing

risk following an incident of tying ligature. Staff did not follow the patient's observation plan after the incident and left the patient's door closed at night despite the patient being on continuous staff observation within eyesight. The provider identified another occasion when staff failed to follow a patient's prescribed level of observations. Staff were sitting outside the patient's bedroom, with the door shut, despite enhanced observations requiring the staff to keep the patient within eyesight of staff at all times. Staff left the patient unobserved when responding to an emergency. Managers and staff had failed to learn lessons to ensure patient safety, or to ensure the provider's observation policy was adhered to. This posed an ongoing risk of significant harm to patients.

- Managers did not ensure staff followed the provider's policy for observing patients. Staff were completing periods of continued enhanced observation of patients without a change of activity. We reviewed the observation records for three patients and found four incidences where staff had remained on continuous observations for more than two hours. The provider's policy stated that staff should not be on continuous observations for more than two hours without a break or change of activity. The National Institute for Health and Care Excellence guidance (NG10) requires staff to undertake periods of continuous observation for no longer than two hours, due to the intense nature of this intervention and its associated risks.
- Staff did not always complete observation records in accordance with the provider's policy. Staff did not always fill in details of who was doing observations at a specific time and did not keep records in chronological order. Staff did not always use the same sheet for recording observations completed on the same day. We found that staff had attached part of one day's records to the previous day. This did not provide a clear contemporaneous record and was confusing.
- Staff were not always aware of how to deal with specific risk issues such as choking. A speech and language therapist had assessed a patient and a care plan had written that the patient required a soft diet. Staff had not followed the patient's care plan. This resulted in them choking twice in the same day and requiring urgent intervention. This posed a significant risk to patient safety.
- The provider was implementing plans to reduce restrictive interventions. The provider's regional lead for physical interventions and reducing restrictive practice had completed an assessment of the service. Whilst this did not comment on physical intervention it did give feedback about how staff had reduced restrictive practice and actions to further improve this.
- Staff restrained patients on 204 occasions between May 2019 and October 2019. We saw evidence on closed circuit television of staff attempting to verbally deescalate patients when they became aggressive. Staff used physical restraint only when verbal de-escalation was not successful. We saw that staff released their hold on patients as soon as possible to promote least restrictive practice. However, we saw on three occasions, where staff released the patient from the restraint and the patient continued to present as agitated and aggressive and attempted to assault staff. This put staff and the patient at risk of further harm.
- Staff considered patient views when planning activities. Staff had completed a review of the activity programme to provide more meaningful activities for the patients. Staff had discussed with patients what activities they would like and used this information to assist in the development of a new programme. The provider had employed an activity coordinator to assist with managing the activity programme.
- Staff completed risk assessments of patients on admission. Staff updated these regularly as part of patients' care review or following an incident or change of risk level.

Safeguarding

- Staff did not always report safeguarding concerns to the local authority. We found three occasions where staff had not reported incidents of patients being the target for assault by other patients and as such, staff had not made the necessary safeguarding referrals. Some patients' safeguarding plans did not fully reflect the level of risk posed to them and what staff should do to reduce incidents.

Staff access to essential information

- Staff had access to all essential information needed to care for patients. Information was easily accessible via the online recording system which all staff were able to access including bank and agency staff.

- The provider kept paper records of essential patient information such as care plans and risk assessments in case of a breakdown of technology. Staff kept these in a locked filing cabinet in the office, so it was easily accessible.

Track record on safety

- Information provided by the provider following the inspection showed there had been 391 incidents between 01 May and 31 October 2019. Out of the 391 incidents, 312 involved violence and aggression. Other incidents included self-harm, attempted suicide, choking and slips trips and falls.
- The provider had one serious incident in the past six months. Whilst staff were restraining a patient, the patient suffered a significant injury. The provider's investigation is ongoing. We found 2 other incidents that should have been considered as serious incidents.

Reporting incidents and learning from when things go wrong

- Staff did not always know what incidents to report or when to report them. We reviewed 15 incidents documented in the daily case notes of three patients. We found four incidents that staff had not reported on the incident reporting system. We interviewed senior staff who acknowledged this had been an issue and they were working to make improvements to oversight and governance systems. Whilst improvements were in their infancy, we saw evidence of changes the provider was implementing.
- Staff understood their responsibilities in regard to duty of candour. We saw evidence that following an incident staff had contacted the family to explain what had happened and what action staff had taken to ensure it did not happen again.
- Staff did not always receive feedback from investigations into incidents and senior staff did not routinely share lessons learned. We reviewed team meeting minutes for the past three months and could not see evidence that staff discussed incidents. Senior staff told us they had recently introduced a governance meeting where staff discussed incidents. We reviewed the minutes of this meeting and saw incidents were part of the agenda. However, the minutes stated that they would discuss incidents the following month. Staff did not, therefore, receive this information in a timely manner. We checked a sample of staff shift handover meeting minutes which gave details about the reported incident's, but they did not capture the lessons learnt, or actions staff should take to reduce the risk of reoccurrence.

Are wards for people with learning disabilities or autism caring?

Kindness, privacy, dignity, respect, compassion and support

- We saw staff attitudes and behaviours when interacting with patients showed that they were kind caring and compassionate. We saw an example of staff caring for a patient who had fallen. They were respectful and kind and provided emotional support at a time when the patient needed it.
- Patients told us they felt the staff were kind and caring and treated them well. Patients told us that staff made them feel safe on the ward.

Involvement in care

- Staff orientated patients to the ward upon admission. Staff gave patients welcome packs with easy read and pictorial information about the ward. Staff showed patients around the ward and introduced them to staff and the other patients.
- Staff found effective ways to communicate with patient with communication difficulties. Staff supported patients to understand and manage their care and treatment. We saw staff using sign language and Makaton to communicate with patients and staff using pictures boards to explain the day's activities. We also saw staff using a picture board when discussing with a patient what they would like for lunch.
- Two patients told us they were not always directly involved in their care. One patient told us staff wrote the care plans and they would then tell the staff whether they agreed or not. However, we did see evidence where patients had been involved in a community meeting where they discussed the activity schedule and patients chose activities they wanted.
- Patients gave feedback on the service they received. We saw minutes from community meetings where patients had given feedback on the menu and activity programme.

Inadequate

Wards for people with learning disabilities or autism

- Staff ensured patients had access to an advocate. There was information displayed around the hospital and staff supported patients to make contact if required.

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

Inadequate

Leadership

- The provider had not ensured consistent robust leadership and governance at the hospital since our last inspection. We identified risks for the provider regarding incident reporting, incident investigation and learning and staff management of patient risks.
- The new manager had a good understanding of the service. They were aware of areas for improvement and had started to make improvements. The manager had recently employed a deputy manager to assist in improving the standards of care at the service as well as improving the governance structure. A new regional director had recently been employed and had visited the hospital.
- Managers were visible throughout the service. Staff we spoke to told us that managers were regularly on the ward and would help during very busy periods.
- Leadership development opportunities were available for staff. Managers told us that there were opportunities for development of their skills. We saw evidence that junior staff had the opportunity for promotion within the service.

Culture

- The new manager had identified that changes to the staff team and culture were required. Managers dealt with poor performance when needed. We saw evidence in staff files where managers had used the disciplinary procedure to improve the performance of staff following issues of poor performance.
- Staff felt respected and valued by the senior staff. Staff we spoke to told us that the morale within the hospital had improved over recent months and they spoke positively about the recent changes of leadership and culture.
- Staff felt able to raise concerns without fear of retribution. Staff were aware of how to use the whistle blowing policy. Staff told us they were confident if they raised concerns the managers would listen and respond appropriately.
- Staff appraisals included conversations about career development and how the provider could support them to achieve this. We saw evidence in staff files where staff had identified training to improve their skills and knowledge and the provider had supported them to access this for example, training to improve knowledge in positive behaviour support planning.

Governance

- The governance structures at the hospital required development and further review. There was not a clear framework of what staff must discuss at a ward or team meeting to ensure senior staff shared essential information. We reviewed the minutes of three months of team meetings. We could not see any evidence that staff had discussed incidents or complaints. Managers did not share information such as lessons learned from incidents and complaints identified during the investigation process.

Management of risk, issues and performance

- Managers maintained and had access to the risk register. We reviewed the risk register for the provider and saw that it was up to date and reflected the risks within the service. Staff were able to escalate issues to the manager who would include them on the risk register.

Information management

- The provider did not have sufficient oversight of staff compliance with the provider's observation policy. There was no audit process, which would have identified how long staff were spending on observations.
- Staff did not always make required notifications to external bodies. We found evidence where four notifiable incidents had occurred, however staff had not made the necessary notifications to the Care Quality Commission. We also found evidence where staff had not informed the local authority regarding two safeguarding incidents where patients had been the victim of assault by other patients.

Inadequate

Wards for people with learning disabilities or autism

- Staff had access to the equipment and information technology needed to perform their role. The provider had online records systems that was accessible to all staff, including bank and agency staff.
- Information governance systems included confidentiality in patient records. Patient records were on a secure online system and access was restricted to those who needed to access the information.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that governance processes are reviewed and are effective.
- The provider must ensure that staff identify and report all incidents and that they respond to any changes in risk following incidents
- The provider must ensure that lessons learned from investigations into incidents and complaints are shared with staff in a timely manner.
- The provider must ensure staff identify and report all safeguarding concerns.
- The provider must ensure staff are compliant with the provider's observation policy and they follow patients' observation care plans.
- The provider must ensure that all notifiable incidents are reported to the Care Quality Commission.
- The provider must continue to ensure there is robust and sustainable leadership in the service

Action the provider SHOULD take to improve

- The provider should ensure that there is a clear framework of what staff must discuss at a ward or team meeting to ensure senior staff share essential information.
- The provider should ensure that the patients' views are reflected in care plans.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective governance systems in place to ensure the effective monitoring of the service The provider did not have a system in place to investigate incidents, identify and share lessons learned. This was a breach of regulation 17 (2) (a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had not notified the Care Quality Commission of all notifiable incidents This was a breach of regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Staff did not always know what incidents to report or when to report them. Staff did not always follow the provider's policy for observing patients. Staff did not always respond to changes in patient's risk levels. Staff did not always complete referrals to external bodies following incidents of abuse. This was a breach of regulation 12 (1)(2)(a)(b)