Cygnet Thors Park

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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Summary of findings

Letter from the Chief Inspector of Hospitals

The hospital was in special measures at the time of it cancelling its registration and closing.

Professor Edward Baker
Chief Inspector of Hospitals

Overall summary

Cygnet Thors Park is a 14-bed hospital, which provided care and treatment for men aged 18 years and above who have a learning disability, autism and complex needs. The provider has taken the decision to close the hospital: there have been no patients at the hospital since 18 June 2020.

We rated the provider 'inadequate' overall at our inspection in September 2019. We rated the safe and well led domains as 'inadequate. We rated the responsive domain as 'requires improvement' and the effective and caring domains as 'good'.

At our most recent inspection, we did not change amend our previous ratings.

The Care Quality Commission (CQC) placed the hospital in special measures following an inspection in 5 February 2019 and imposed conditions on the provider's registration at this hospital. These included not admitting any new patients; ensuring there were sufficient competent, skilled staff and ensuring observations of patients were carried out appropriately. As a result of placing the provider in special measures we commenced a programme of enhanced monitoring. During this period of enhanced monitoring both the CQC and the provider identified significant areas of ongoing concern.

On 16 June 2020 the provider took the decision to transfer all patients out of this hospital. On 9 July 2020, the provider submitted a notification to the CQC to cancel the registration of this location and has since deregistered.

We undertook a focused, short notice site inspection on 1 and 7 July 2020 because we had concerns about the safety of patients prior to their transfer to new services and concerns about how the provider had undertaken the transfer of patients.

At this inspection we found:

- The provider did not manage the hospital in order to deliver safe, good quality care to patients. They had not provided effective leadership and did not have robust governance processes in place to ensure that the hospital operated appropriately. They did not have oversight of the way staff assessed and managed risks relating to the patients.
- The provider had not ensured they had taken all the necessary action we told it that it must following our September 2019 inspection. They had not acted to ensure staff undertaking observations, did so in line with the provider's engagement and observation policy and protocol. They had not acted to ensure there were always sufficiently skilled and competent staff to support patients .
- The provider had not implemented effective monitoring systems to check that staff were observing patients as specified in their care plans. We considered that patients and others were placed at risk of harm and that there was a risk that patients were not getting the care they needed. Hospital managers informed us of multiple incidents (between April to May 2020) where they had found staff were not observing a patient as per their care plan at night. The provider was investigating a number of night staff (support workers and registered nurses) to determine if they had failed in their duties. We viewed samples of closed-circuit television footage where staff had not observed three patients as their care plans specified. We saw that staff had falsified patient notes stating that they had observed one patient when they had not. Hospital managers informed us on 17 July 2020 that they were now investigating 27 staff; mostly night staff but also some day staff.
- We found an example where the provider had not checked that hospital managers ensured staff followed

Summary of findings

identified learning and recommendations from an incident investigation. The recommendation was to ensure female staff were not allocated to a specific patient due to identified risks but this was not followed. Some staff told us they had raised concerns about patient's continuous observation levels with hospital managers. They said hospital managers had not acted to address their concerns.

- The provider did not have a system of assurance to check that hospital managers had ensured that staff received adequate training, supervision and appraisal. They had not ensured that staff worked well together as a team. They had not ensured that there were sufficient numbers of suitably qualified, skilled, competent and experienced staff at all times to meet the needs of patients. For example, we checked personnel files for 24 staff (of 27) under investigation and found poor pre employment screening and post employment screening of competency. This related particularly to clinical support worker staff.
- The provider had not ensured there was adequate and consistent leadership at the hospital. There had been six different hospital managers (or senior staff) since our last inspection in September 2019. The Care Quality Commission had taken enforcement action in 2019 to ensure the hospital had a registered manager in post. Over the period covered by the last three inspections, the risks identified at the hospital had increased. We found evidence that a culture of poor care had developed particularly during night shifts , where staff did not follow the instructions contained in patient care plans, or the provider's observation policy.

At this inspection we found the following relating to patients transfers out of the hospital:

- Provider staff told us they were closing the service and transferring patients as they could not provide safe care.The provider had not treated patients with respect compassion and kindness, when they transferred patients out of the hospital within 24 to 48 hours. Whilst CQC does not disagree with the provider's decision to close this service for this reason, we were concerned about the extreme short notice period within which these transfers were completed, the difficulties commissioners would have in considering alternative and appropriate placements, the complex needs of the patients and the length of time patients had been within this service.
- There were no apparent individualised plans detailing how staff should best support patients for their transfer to minimise the impact of the sudden move. The provider had not actively involved patients and families and carers in the decision or plans/ preparation for the transfer. They had not given sufficient notice to patients, carers and commissioners about the transfer of patients out of the hospital. Some patients had received care and treatment at the hospital from between 15 months to 17 years and no consideration had been given to the impact and considerable distress the move would cause for them. Patients' care plans showed they all had differing levels of capacity to understand information and differing communication needs and many would not be able to comprehend what was happening or why it was happening at such short notice. One patient had only been given two hour's notice.
- The provider had not ensured that staff developed care plans informed by a comprehensive assessment to support patients transfer. This was not in line with national guidance about best practice. The provider had not planned and managed patient's transfers well and liaised with services that would provide ongoing care and support this includes commissioners and community teams.
- Additionally, the provider had not effectively communicated with their staff, commissioners and the CQC about the transfers. They had not ensured that staff assessed patients' individual needs and developed support plans to give them the support they needed when moving.

Summary of findings

However:

- Hospital managers had ensured staff had reviewed all patients' observation records to ensure that the level of observations prescribed were individualised, detailed specifically when levels of observations should reduce or increase and were based on individual risk assessments, including mitigation of risks identified.
- Hospital managers had ensured there was documentation to inform staff of the current observation level of all patients. This included details of any changes to their observation levels. All documentation was accessible to relevant staff.

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		Cygnet Thors Park operated as an independent hospital that provided support for up to 14 men.

Summary of findings

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Cygnet Thors Park

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

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Background to Cygnet Thors Park

Cygnet Thors Park operated as an independent hospital that provided support for up to 14 men. The provider is Cygnet (OE) Limited. The hospital in Thorrington, North East Essex, Cygnet Thors Park provided support and treatment for men with learning disabilities and complex needs. The provider accepted patients who had additional mental and physical health needs, and those who are detained under the Mental Health Act. The service comprised of three elements:

- Thorrington Ward had eight-beds that provided assessment and intervention for men with learning disabilities, complex needs and behaviours.
- Brightlingsea ward had four-beds for men who required more intensive support. There were also four self-contained, bespoke apartments.
- The provider also had two bespoke single person apartments that provided a more independent living environment.

This location was registered with the Care Quality Commission on 1 October 2010 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 hospital did not have a registered manager. The previous registered manager was not available from December 2019 and they left in March 2020. The provider arranged for their two regional managers to act as the hospital's manager in the interim. The provider appointed a new hospital manager who submitted a registered manager application 8 July 2020.

The hospital was placed in special measures after a comprehensive inspection 5 February 2019. The CQC took enforcement action and issued a warning notice under section 29 of the Health and Social Care Act 2008. This related to a breach of Regulation 12 safe care and treatment: regarding medicines management, environmental issues including the medicines clinic, the staff alarm system and also staff observation of patients. Regulation 17 good governance: regarding the provider's oversight and mitigation of risks. Regulation 18 staffing which related to staff training, supervision and appraisal.

We carried out a follow up inspection visit on 24 and 30 September 2019 to check on the provider's actions and issued a notice of decision to urgently impose conditions under section 31 for a breach of regulation 12 safe care and treatment, regulation 17 good governance and regulation 15 premises and equipment. The conditions restricted the admission of patients, related to having suitably competent and skilled staff and ensuring staff's observation of patients were in accordance with patient care plans and the provider's policy. Since this inspection, the provider sent the CQC information outlining how they were addressing the breaches of regulation relating to the conditions.

The provider applied 9 July 2020 to cancel their registration of regulated activities at this location. They had transferred all their patients out of the hospital by 18 June 2020.

Our inspection team

The team that inspected the service comprised two CQC inspectors and two inspection managers. Additionally, an expert by experience spoke with the carers of patients who had used the service.

Summary of this inspection

Why we carried out this inspection

In line with our published guidance for locations in special measures, the CQC was planning a further comprehensive inspection within six months of last date of report publication. Due to the COVID-19 pandemic and national 'lock down' restrictions, the CQC deferred this inspection.

However, CQC continued its enhanced monitoring and assessment of information from the provider and others. We received concerning information from the provider relating to staff not observing patients as per their care plan and the CQC planned to carry out a focused short notice inspection. We initially planned to visit the hospital 17 June 2020, but we changed the date for this as we learnt the provider was transferring patients. We did not want to cause additional stress for staff and patients at that time. The provider had transferred their remaining five patients to other Cygnet hospital sites between 16 to 18 June 2020. When we inspected on site 1 July 2020, there were no patients at the hospital.

How we carried out this inspection

Our focused, short notice inspection of this location was very specific to verify the information the provider had given us relating to staff not observing patients as per their care plans. We also focused on the provider's management of the patients transfer out of the hospital. We have reported under each of the five key questions: are services safe, effective, caring, responsive and well led, but we have not reported on all aspects of each key question.

Before the inspection visit, we reviewed information that we held about the location. This included fortnightly reports and information sent by the provider to the Commission as part of the imposed conditions. We also met and had contact with provider staff and stakeholders prior to the inspection.

We gained information from commissioners via a stakeholder/risk summit meeting on 22 June 2020. We requested closed circuit television footage from the provider 26 May 2020 but had difficulties viewing this using our systems, so we checked footage when we visited the hospital.

We carried out this inspection over several days from 23 June to 24 July 2020. Due to the COVID-19 pandemic national lockdown and a change in CQC methodology, we announced to the provider we were going to inspect them 18 June 2020. We had contact with carers between 23 and 26 June 2020. We visited the hospital site 1 and 7 July 2020. We carried out telephone/video conference interviews away from the hospital site with staff, from 17 to 24 July 2020. We also reviewed off site information that the provider sent to us.

During the inspection we:

- Requested and viewed a sample of the provider's closed-circuit television footage at the hospital;
- Looked at records staff completed for their observation of patients (for the sample of footage seen);
- Looked at the care and treatment records of all five patients;
- Looked at personnel records for the 24-night staff the provider told us (as of 01 July 2020) were under investigation;
- Asked to speak to sample of 13 nurse and support workers. Not all staff were available or wanted to speak with us, we spoke with four staff;
- Spoke to the hospital manager, clinical manager and consultant psychiatrist for the hospital;
- Spoke with the independent advocate for the hospital;
- Contacted all five patients' carers and spoke with three of them;
- Looked at a range of policies, procedures and other documents relating to the running of the service;
- Requested further information from the provider after our site visit.

Summary of this inspection

What people who use the service say

When we inspect, we usually speak to patients to gain their views on their care and treatment. At this inspection, we decided not to speak with the patients as they had been transferred out of the hospital and, due to their complex communication needs, virtual meetings were considered inappropriate. We also did not want to unsettle them whilst they were adjusting to their new placements. We had spoken with the hospital advocate on the 14 May 2020 and they did not identify that patients had any concerns about their care and treatment. We had carried out a remote Mental Health Act reviewer inspection 8 and 9 June 2020 and no patients had wanted to speak to us.

Our expert by experience attempted to contact all the patients' carers/relatives and they gained feedback from three carers.

All carers expressed their concerns about how the provider had managed the patients' transfer out of hospital.

All considered that they and their relative had not been given sufficient time to process the change and find out about the new placement.

All said that as the provider transferred patients to other Cygnet hospitals, they were worried that the provider could make the decision to transfer the patients at short notice again.

All carers stated that they did not hold individual hospital staff accountable for the way that the transfers took place but considered this was a failing at provider level. Two of three carers gave us positive feedback about staff's care of patients (not relating to the transfer). For example they told us staff had helped a patient during COVID-19 national lockdown to continue with gym workouts and had ensured there were staff with the same race/ethnicity to give him support. Another carer was positive about the occupational therapist support and help for a patient.

We asked the provider for any latest patient or carer survey results to give additional information on how patients and carers viewed the overall care and treatment provided at the hospital. We saw previously hospital staff had held 'patient empowerment meetings' for patients to give feedback on the service. The provider had completed a survey with patients in December 2019. It showed all patents responded with 'yes' for the question asking if staff were polite and treated them with respect.

The provider had completed a survey with carers in January 2020. Four carers had responded giving mostly positive feedback. Four carers gave feedback that staff were friendly and caring and stated that patients needs were met. One carer identified that communication needed improving. Hospital staff had developed an action plan for the feedback gained.

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?

We did not rate the service at this focused inspection.

At this inspection we found:

- The provider told us on 22 June 2020 that they had given notice to commissioners on 16 June 2020 that they would transfer patients out of the hospital within 24 to 48 hours. They said this was because they could not keep the patients safe. The provider applied on 9 July 2020 to cancel their registration of regulated activities at this location.
- Prior to all the patients being transferred, the provider had not ensured nursing staff kept patients safe from avoidable harm. They had not ensured staff assessed and managed risks to patients to ensure staff observed patients as per their care plan. The provider had not ensured staff had the skills required. We considered that patients and others were placed at risk of harm because of this. We checked samples of closed-circuit television footage from 30 April 2020 to 15 June 2020 which showed staff were not observing three patients as their care plans specified. We saw examples where staff had falsified records stating that they had observed the patient when they had not. We found an example where the provider had not checked that staff followed identified learning and recommendations following an incident investigation.
- There was a risk that patients were not getting the care they needed. When we visited the hospital 1 July 2020, hospital managers were investigating 24 of their registered and unregistered nursing staff regarding incidents related to staff observation of patients. They had suspended some staff then decided to bring staff back to work with patients but there was no apparent individual staff risk assessment to ensure they did not pose any risk to patients. CQC staff identified from checking a sample of six staff investigation interview reports available, that staff had an understanding of the different types of observation levels but that they were not following these for specific patients. Hospital managers informed us 17 July 2020 they were now investigating 27 staff mostly night staff but also some day staff.
- Some staff told us they had raised concerns about a patient's continuous observation levels with managers. They considered

Summary of this inspection

the practice was overly restrictive and considered the checks disturbed the patient's sleep and upset them. They said managers had not involved them when they updated patients care plans and had not acted to address staff's concerns.

- The hospital had not met the provider's target for staff mandatory training of 95%, instead only 63% of staff had completed it as of 28 May 2020. Twenty two of 24 staff records seen showed that staff had not completed all mandatory training identified by the provider for their role. From a sample of 24 staff training records checked, ten staff had not completed the provider's latest observation training.

However:

- The provider had implemented a new electronic incident reporting system to make it easier for staff to report incidents, and for managers and others to identify any themes or trends.
- Twenty one of 24 staff records showed had completed safeguarding training. The clinical manager was the designated safeguarding lead. The consultant psychiatrist was completing level five, specialist role - designated professionals' training.

Are services effective?

We did not rate the service at this focused inspection.

At this inspection we found:

- The provider had not ensured they had staff with a range of skills needed to provide high quality care. They had not supported staff with appraisals, supervision and opportunities to update and further develop their skills.
- As of 28 May 2020 85% of staff had received appraisals and supervision. However, seven of 24 staff (29%) supervision records held limited information of how supervisors were checking that staff had support and were competent in their role. Seven of 24 (29%) staff records we checked did not have supervision as per the provider's standard of one session each quarter. Records held limited information to show managers completed probation checks for new staff to ensure they received support and were working to the provider's standard. Five staff appraisal records lacked sufficient information to show the appraiser had checked that staff were suitably skilled and competent or needed support. Six staff had not had an appraisal of their work in the time frame identified by the provider. However, the hospital manager was completing eight staff appraisals when we visited on 7 July 2020. The provider

had not ensured reviews of staff pre employment checks took place. Eleven of 24 staff under investigation at the location lacked information to show they were suitably qualified, skilled, competent and experienced.

Are services caring?

We did not rate the service at this focused inspection.

At this inspection we found:

- The provider had not treated patients with respect, compassion and kindness, when they transferred patients out of the hospital with only 24 to 48 hours notice. Whilst the CQC does not disagree with the provider's decision to close this service for this reason, we were concerned about the extreme short notice period within which these transfers were completed, the difficulties commissioners would have in considering alternative and appropriate placements, the complex needs of the patients and the length of time patients had been within this service.
- There were no apparent individualised plans detailing how staff should best support patients for their transfer to minimise the impact of the sudden move. The provider had not actively involved patients and families and carers in the decision or plans/preparation for the transfer. They had not given sufficient notice to patients, carers and commissioners about the transfer of patients out of the hospital. Some patients had received care and treatment at the hospital from between 15 months to 17 years and no consideration had been given to the impact and considerable distress the move would cause for them. Patients' care plans showed they all had differing levels of capacity to understand information and differing communication needs and many would not be able to comprehend what was happening or why it was happening at such short notice. One patient had only been given two hours notice before they were transferred.
- Patients were not given any choices about where they could move to. This was not in line with National Institute for Health and Care Excellence guidance/best practice for people with leaning disability and /or autism.
- Five commissioners and three carers gave us feedback they were concerned about how the provider informed patients and prepared them for the transfer. Managers told us that two carers had made formal complaints about the patients transfer, which

they were investigating. Staff we spoke with were distressed about the way the provider had managed the patients' transfers and the potential impact this might have on future treatment and outcomes.

However:

- Two of three carers gave us positive feedback about staff's care of patients (not relating to the transfer). Carers we spoke with, said that they did not hold individual hospital staff accountable for the way that the transfers took place but considered this was a failing at provider level. Patients' records showed that staff had not told one carer about the move until after the patient had left the hospital.
- One patient was able to meet staff from their new hospital prior to their transfer. Other staff accompanied other patients during their transfer journey and remained at the new hospital to offer support whilst patients settled. Cygnet Thors Park staff made contact with the new hospitals after the patient transfers to offer support and advice to help care for the patients. The hospital advocate contacted their counterparts at the new hospitals to request ongoing support for patients.

Are services responsive?

We did not rate the service at this focused inspection.

At this inspection we found:

- The provider had not planned and managed the patient transfers out of the hospital well. They had not liaised well with services that would provide ongoing care and support this includes commissioners and community teams.
- The provider gave conflicting information to commissioners about the time frame to transfer/discharge patients. Initially they gave 28 days' notice for the transfers then within a day this timeframe changed to 24 to 48 hours' notice. Commissioners gave feedback at a stakeholder meeting on 22 June 2020 that they were not given adequate time to make arrangements to move patients or consider alternative placements. This meant they had little option but to accept the provider's offer of a placement at one of their other hospitals. The provider had not ensured the patients' transfers were in line with the national 'transforming care' agenda enabling patients to live outside of hospital in the community, with the right support, and close to home.
- Patients' discharge plans (developed some time before the transfers) showed patients, their carer and commissioners were

planning for patients to move to community placements. Two commissioners expressed concerns to us that this unexpected transfer to another hospital would destabilise the patient and delay the discharge plans already in place.
- The provider had not ensured that staff had sufficient time to assess the risk for individual patients and develop care plans to manage the transfer. There was a risk that staff did not know how best to support the patient in their transition and if additional support was needed.
- The provider had not developed a clear communication plan to notify staff about the patient transfers and closure.

Are services well-led?

We did not rate the service at this focused inspection.

At this inspection we found:

- The provider had not managed the hospital well. They had not ensured they fully addressed the conditions Care Quality Commission imposed after our last inspection September 2019. They had not ensured they had sufficient skilled, competent staff who observed patients in line with the provider's engagement and observation policy and protocol.
- The provider had not ensured there was adequate and consistent leadership at the hospital. The hospital had six managers (or senior staff) since our last inspection. Three of these were new to the organisation as well as the hospital. The Care Quality Commission had raised to the provider that this was a risk for the hospital. The lack of consistent management and oversight had meant that risks were not managed. As a consequence this affected patients, carers and staff as the provider then closed the service.
- Whilst leaders such as the chief executive officer had visited and had contact with the hospital, their support and governance systems for assessing and monitoring and managing risks at the hospital was not fully effective.
- The provider had not adequately assessed that the staff providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. The provider had failed to ensure staff had thorough pre and post employment checks.
- The provider had not effectively communicated with the Care Quality Commission about their change of notice period for patients. Instead it was commissioners of patients' care who told us. They had not effectively communicated with patients, carers, commissioners and staff about the patients' transfers. The provider had not ensured staff assessed patients'

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individual needs and developed support plans to give them the support they needed when moving. There was no apparent risk assessment considering COVID-19 and national restrictions and the level of risk this could pose to patients when moving.

- We found evidence that a culture had formed within the night shift periods, whereby staff had not followed the instructions contained in patient care plans, or the provider's observation policy. Some staff told us they were not respected, supported and valued. Some told us they were unable to raise concerns without fear of retribution.

However:

- The provider had acted to address some of the Care Quality Commission imposed conditions after our last inspection. Staff had improved patients' records to show more clearly the level of observations staff needed to give patients. The provider had taken action to reduce the number of hours staff observed patients to avoid them being tired and not able to concentrate. They gave reports to the Care Quality Commission on their actions.
- The provider appointed a new substantive hospital manager in May 2020, who had instigated checks on staff competency to observe patients. The hospital manager took swift action, once notified by leaders about plans to transfer patients, to ensure there were ways in which staff at Cygnet Thors Park could support the patients ongoing care and treatment. For example, regular contact with the new hospitals to share important information about how to best care for the patients.
- The provider had conducted a 'closed culture' survey with staff and developed an action plan to respond to issues raised. This included ensuring staff knew they could contact the speak up guardian and arranging six weekly site visits. They arranged human resources clinics every six weeks.
- The provider had set up a regional patient safety meeting giving managers from their Essex hospitals an opportunity to meet and share learning and best practice.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Wards for people with learning disabilities or autism

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are wards for people with learning disabilities or autism safe?

Safe staffing

Hospital managers were investigating a significant amount of their registered and unregistered nursing staff regarding incidents relating to staff observation of patients. There was a risk that patients did not get the care they needed.

Hospital managers notified the CQC in May 2020 when they started to uncover incidents of staff not observing patients as per their care plan. As time went on the amount of staff the provider was investigating increased. The provider told us on 17 July 2020 that they were investigating 27 staff. This included some day staff.

Hospital managers told us on 21 May 2020 that initially staff were suspended pending an investigation. They later told us they were returning them to work and other staff identified in the investigation were not suspended. There was no apparent individual staff risk assessment for this to ensure they did not pose any risk to patients. Other than a request that the nurse in charge made hourly checks of staff, the provider had not arranged for other additional oversight/support planned for them.

Following contact with the CQC on 21 May 2020, hospital managers told us they had ensured managers were on shift 24 hours a day to give greater checks/staff support. Later the provider gave us a copy of a corporate risk assessment dated 24 May 2020 with their assessment and actions which confirmed this action was taken following our contact.

Initially the provider gave notice on 15 June 2020 of transfer of all patients within 28 days. At a stakeholder meeting 22 June 2020 the provider told us that they had decided to transfer patients at short notice on the 16 June 2020 as they could not keep the patients safe. Managers told us they had arranged for staff from other sites to work at the hospital. However, it was considered impossible to continue this for 28 days. The provider had then given notice 16 June 2020 they were transferring all patients within 24 to 48 hours. They transferred all patients out of the hospital by 18 June 2020. The provider applied 9 July 2020 to cancel their registration, effectively closing the hospital.

Hospital managers initially redeployed staff who were not being investigated to other Cygnet locations. They gave other staff under investigation paid leave until the outcome of the investigation. We asked the provider to be kept updated on the outcome of their investigation. They had not sent us their further risk assessment for staffing.

Information from the provider 12 June 2020 showed that they had two qualified nurses and nine clinical support workers on duty in the day and at night.

The provider had employed 47 nursing staff:

- Seven registered nurses: four worked night and three worked day shifts.
- 40 clinical support workers: 17 male staff worked day and 13 worked night shifts ; 10 female staff: four worked night and six worked day shifts.

The CQC had imposed conditions on the provider's registration to restrict admissions at the hospital. Consequently there was more staff available than required as there were only five patients in the service before it closed. We saw that staff were loaned to the provider's other local hospital and social care locations to ensure staff fulfilled their 40 hours a week contract.

Staff raised that they did not always have sufficient breaks during their shift. We saw from staff meeting minutes that staff had raised this issue 30 October 2019.

Staff meeting minutes 28 May 2020 stated 63% compliance with mandatory training as identified by the provider. Staff were given two weeks to update training.

Twenty two of 24 staff records we checked showed staff had not completed all mandatory training identified by the provider for their role. Sixteen of 24 staff had not completed training for the provider's new electronic patient record system started on 1 August 2019. This posed a risk staff would not know how to access/complete patient records for their role.

Assessing and managing risk to patients and staff

The provider had not ensured that staff identified and responded to any changes in risks to, or posed by, patients relating observation levels after our September 2019 inspection. They had not ensured that staff followed the provider's policies and procedures for observation of patients to keep them safe from harm. We consider that patients and others were placed at risk of harm because of this.

Hospital managers informed us in May 2020 of multiple occasions between 30 April and 19 May 2020 where staff had not observed patients as per their care plan. Additionally they had evidence that staff had falsified records stating they observed patients when they had not. The provider told us that were no incidents of harm to patients or others as a result of staff not following plans.

Closed circuit television footage

We checked 18 samples of closed-circuit television footage from 30 April 2020 to 15 June 2020 to verify information about the incidents the provider had told us about. We also checked more recent footage. Nine samples showed staff were not observing three patients as per their care plan. Four related to the day shift and five related to night shift. Six samples showed no staff in area to observe the patient. Five samples showed lone staff working when there should have been two staff observing a patient. Five samples showed staff appearing to be asleep. None of these were in samples after 20 May 2020.

We checked staff observation records and patient notes and staff had documented they were observing the patient in eight of nine occasions. There were four examples where a nurse (in charge of the shift) had documented in patients' notes they were being observed. Our review of closed-circuit television confirms the records did not correlate with observation checks recorded. We therefore concluded that staff had falsified patient observation records. Hospital managers gave us examples (chronologies) of samples of closed circuit they had checked. We checked closed-circuit television footage for four of these and noted the information given to us was accurate.

Quality checking systems

Staff told us that the nurse in charge and managers made spot checks of staff throughout day and night shifts to check they were following patients' care plans and observing patients. That they signed the observation records when this was done. Staff told us there were checks each shift and in the daily morning communication meeting, that staff had completed observation records.

We checked a sample of five 'high level and continuous engagement and observation record' documents for one patient. These did not clearly show that the nurse in charge or manager had checked that staff were observing patients and that the notes were accurate. All five had been signed by the clinical manager on the front. Two of the five seemingly had the initials at the bottom of pages of the nurse in charge of the shift, although this was not clear. For all five occasions we identified staff were not always observing patients at the times they had recorded.

The provider had not ensured there were effective systems to check that staff were observing patients appropriately. The provider's action plan for improvements after our last inspection, included staff spot checks of closed-circuit television footage. A quality assurance manager carried out regular audits. The provider had updated their observation policy 27 April 2020 and had introduced new training and staff competency checks.

The provider's quality assurance system had not identified the risk of staff not observing a specific patient until May 2020. The new hospital manager started checking closed circuit television footage to check that staff were correctly observing patients and had detected the incidents.

Staff training

We checked a sample of 24 staff records. Ten out of 24 staff had not completed the provider's latest observation training. This did not align with an audit completed on 11 June 2020, which recorded that all staff had received training.

The provider had a new electronic training monitoring system and we could not access previous old system to

show staff had received training previously. A hospital manager showed us an email they had arranged training for senior clinicians for March 2020. Unit led clinical governance team meeting minutes dated 16 December 2019, referenced that staff had completed 'Observation and engagement training' on 7 October 2019.

All staff had completed a competency check relating to staff observation of patients. We found that seven staff's competency checks were of poor quality, for example supervisors had noted they should complete them again. The provider uses this staff competency checking tool across other hospitals. Therefore there is a risk this tool does not effectively check staff's competency to observe patients.

CQC staff identified from checking a sample of five staff investigation interview reports available that staff had an understanding of the different types of observation levels but that they were not following these for a specific patient. Some staff told us they had tried to discuss the patient's level of observations with the multi-disciplinary team but were not listened to. Staff also raised concerns about inadequate equipment to observe safely, such as a torch and appropriate seating.

Safeguarding

Hospital managers informed the CQC that they had notified the local authority (Essex County Council) about the alleged neglect of patients and staff found not be observing them as per their care plan. The CQC subsequently contacted the local authority to ensure they were aware of the number incidents. We asked the provider to send us separate notifications for the new incidents (relating to 30 April to 19 May 2020), but these were not provided, as legally required.

Information from the provider showed there were six safeguarding incidents reported between April and June 2020. Five of these related to allegations of neglect and staff not observing patients.

Information from the provider showed 21 of a sample of 24 staff had completed safeguarding training. The clinical manager was the designated safeguarding lead. The consultant psychiatrist was completing level five, specialist role - designated professionals, training.

Track record on safety

Provider information from April to June 2020 showed 63 incidents. Themes included: violence and aggression directed towards staff and incidents generated by one patient in relation to aggression and self harming.

There was one serious incident, identified on 19 May 2020, relating staff failure to undertake observations in line with care plan and policy; falsification of records and sleeping on duty.

There were no 'never' events. A never event is the "kind of mistake (medical error) that should never happen" in healthcare.

Reporting incidents and learning from when things go wrong

We found an example where the provider had not checked that staff followed identified learning and recommendations from an incident investigation. Hospital managers notified us of an incident December 2019 where a patient self harmed when staff were supposed to be continuously observing them. The provider's investigation had identified as a recommendation that female staff should not be allocated to observe the patient. However, we found nine occasions between 18 and 30 April 2020 where female staff were observing the patient when should have been male only. Some staff told us that they had raised concerns with managers that the person coordinating staffing rotas had not ensured sufficient male staff were on duty to cover this. We saw from staff meeting minutes 30 January 2020 that staff had requested sufficient male staff available to safely cover these observations.

The provider had implemented a new electronic incident reporting system to make it easier for staff to report incidents, and for managers and others to review any themes or trends. Staff told us they reviewed information about incidents and learning via staff shift handovers, team meetings and lessons learnt bulletins.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Skilled staff to deliver care

The provider had not ensured that managers checked that staff had the right skills, qualifications and experience to

meet the needs of the patients in their care, including bank and agency staff. The provider had not sufficiently checked that managers recognised poor performance, could identify the reasons and dealt with these.

The provider had not sufficiently checked that managers supported non-medical staff through regular, constructive clinical supervision of their work. Managers feedback to staff in October and December 2019; January, April and May 2020 team meeting minutes recorded that they needed to ensure greater compliance for staff supervisions and needed to meet the provider identified minimum target of 95%. As of 28 May 2020 that the staff appraisals and supervision compliance was 85%. Seven of 24 staff (29%) supervision records held limited information of how supervisors were checking that staff had support and they were suitably skilled and competent. For example, we saw cut and pasted information repeated in different records and limited information about staff's progress and actions. Seven of 24 staff did not have supervision as per the provider's standard of one session each quarter.

The provider had not sufficiently checked that managers supported staff through regular, constructive appraisals of their work. Five staff appraisal records lacked sufficient information to show the appraiser had checked that staff were suitably skilled and competent or needed support. Six staff had not had an appraisal of their work in the time frame identified by the provider. However, we noted the hospital manager was completing eight staff appraisals when we visited on 7 July 2020.

The provider had not sufficiently checked that managers ensured staff attended regular team meetings or gave information from those they could not attend. Staff team meeting minutes from October 2019 to May 2020 showed the majority of night staff did not prioritise attendance at team meetings to meet hospital managers and the multi-disciplinary team get important updates on the service and give their feedback. For example, six staff had not attended any staff meeting since October 2019 to May 2020, eight staff had attended once, and six staff had attended twice in that time. Only four staff were attending meetings regularly. We found reference in supervision records of night staff having difficulty attending staff meetings

The provider had not sufficiently checked that managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We have reported on this further in the 'safe' domain. We identified anomalies in two staff training data and staff personnel file information. For example, staff had supervision not logged on the system and staff did not have supervision records in files. We raised this for the provider's awareness.

The provider had not ensured staff had robust pre employment checks. We found checks of 11 of 24 staff under investigation at the location did not show they were suitably qualified, skilled, competent and experienced. Four of these were recruited after our last inspection (or changed roles). For example, we found incomplete or poor quality/applications; poor answers to questions asked, limited information on interview records to show the interviewer's rationale for employing the person. Where interview records gave scoring there was no apparent key to show what the scoring systems/pass rate was. One interview record for December 2019 showed only one interviewer, not in line with the provider's recruitment policy. One record did not hold details of when a nurse had passed their preceptorship/competency check. There was no risk assessment or documentation recorded on the file for a new member of staff employed to work on the night shift to ensure they got the support they needed.

There was limited evidence of probation checks having taken place for seven staff as per the provider's policy to ensure staff had support in their work and also to check staff were suitably skilled and competent. We requested further information about this from the provider, but this was not provided. We did not see that new staff received monthly supervision for the first six months. Some staff told us they had to request supervision rather than being offered it and had to initially find their own supervisor.

Managers gave each new member of staff an induction to the service before they started work.

Are wards for people with learning disabilities or autism caring?

When we inspect, we usually speak to patients to gain their views on their care and treatment. At this inspection, we decided not to speak with the patients due to their complex communication needs. We also did not want to unsettle them whilst they were adjusting to their new placements. We had spoken with the hospital advocate on 14 May 2020 and they did not identify any concerns that

patients had about their care and treatment. We considered that when we had carried out a remote Mental Health Act reviewer inspection 8 and 9 June 2020 no patients had wanted to speak to us. Instead our expert by experience tried to contact all patients' carers/relatives and they gained feedback from three of them.

Kindness, privacy, dignity, respect, compassion and support

The provider had not ensured that staff used appropriate communication methods to support patients to understand their transfer. There were no plans developed by staff detailing the best way to communicate to individual patients they were moving. The provider had not involved the hospital advocate in supporting patients understand their transfer. Three of five patient records showed staff gave patients short notice about the move. We considered this was insufficient time for patients with communication and cognitive difficulties to process the significant life change. Two records showed staff had told patients less than three hours before. Staff records for one patient showed staff told them they were going to two different placements in the two days before, which we considered was confusing. Two records did not detail how staff had communicated the move to them, although we found staff had developed a pictorial social story document for one patient the morning of their transfer. A manager contacted the nurse in charge on duty to clarify this for us how one patient was informed, and they had told them but not documented this. Patients had received care and treatment at the hospital for between 15 months and 17 years. We noted three patients had incidents within two days of transfer to their placement.

The provider had not ensured that staff gave patients help, emotional support required for their transfer out of the hospital. There were no plans or documents developed by staff showing how they planned to support individual patients before and during the moves. Therefore we were not assured that the provider or their staff had given patients adequate support to move. Staff had documented in a patient's notes they had asked for a particular staff member but were told they were not on duty to support them. However, managers had told us that one patient had met some of the staff from another hospital prior to transfer. We understood that the provider had arranged for some staff to accompany patients and stay to help with their transition. Managers gave us a copy of the provider's closure plan 18 June 2020 and staffing rotas 15 June to 5 July 2020 which referenced to staff shadowing at two of the hospitals that patients had moved to. Eighteen staff were sent to one hospital and two to another. Hospital staff contacted the hospitals patients went to and offered staff support to care for patients. The hospital advocate contacted their counterparts at the new hospitals to request ongoing support for patients.

Five commissioners and three carers gave us feedback they were concerned about how the provider informed patients and prepared them for the transfer .

Two of three carers gave us positive feedback about staff's care of patients (not relating to the transfer). For example they told us staff had helped a patient during COVID-19 national lockdown to continue with gym workouts and had ensured there were staff with the same race/ethnicity to give him support. Another carer was positive about the occupational therapist support and help for a patient.

Some staff we spoke with said they would have wanted to say good bye to patients who they had worked with. Most staff did not know what support patients got for the transfer. Two staff told us that a patient was upset (and carer) and did not want to leave and be placed so far away from their home area.

One staff told us that the CQC did not focus on the positive work staff had achieved with patients and the progress patients made. We asked the provider for any latest patient or carer survey results to give additional information on how patients and carers viewed the overall care and treatment provided at the hospital. We saw previously hospital staff had held 'patient empowerment meetings' for patients to give feedback on the service. The provider had completed a survey with patients in December 2019. It showed all patents gave a 'yes' response for the question asking if staff were polite and treated them with respect.

The provider had completed a survey with carers in January 2020. Four carers had responded giving mostly positive feedback. Four carers gave feedback that staff were friendly and caring and state that patients needs were met. One carer identified that improvements in communication were needed. Hospital staff had developed an action plan for the feedback gained.

Involvement in care

The provider had not ensured that staff involved patients in their care plans and risk assessments before the transfer.

Wards for people with learning disabilities or autism

The provider had not ensured that staff supported, informed and involved families or carers in the transfer. We checked all patients' care plans the week prior to transfer and staff had not updated them to show partnership between the provider, the patient and their family and carers to help inform/manage transfers. This was not in line with National Institute for Health and Care Excellence guidance/best practice for people with leaning disability and /or autism.

Staff had documented in patients records that they contacted two patients' carers after the patient had moved. Three carers gave us feedback that they were concerned about how the provider had managed the patients' transfer out of hospital. All considered that they and their relative had not been given sufficient time to process the change and find out about the new placement. All were concerned that the same thing could happen again at their new placement.

Hospital managers gave us a copy of a letter sent to carers. This gave limited information about where the patient would move to, their care plan/support given and the rationale. Managers told us that two carers had made formal complaints about the patients transfer, which they were investigating.

All carers stated that they did not hold individual hospital staff accountable for the way that the transfers took place but considered this was a failing at provider level.

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

Access and discharge

The provider had not ensured that staff carefully planned patients' transfers/ discharge and worked with care managers and coordinators to make sure this went well.

Provider staff gave conflicting information to commissioners about the time frame to transfer/discharge patients. The provider notified them on 15 June 2020 that they were giving 28 days' notice to move the patient/s. The provider then gave 24 hours' notice to commissioners, 16 June 2020 to move patients or they would transfer them to other provider location/hospital.

Commissioners told us at a stakeholder meeting on 22 June 2020 that the provider had not given them adequate time to make arrangements to move patients. This meant they had little option but to accept the provider's offer of a placement at one of their other hospitals. One carer told us they had informed the patient's community team about the revised transfer timescale.

The provider had not adequately planned and managed the transfer of patients out of the hospital. Senior provider staff had told us at a stakeholder meeting on 22 June 2020 that a meeting was held to determine this. There was not a record available to show this. Staff had not documented in patient records the provider's assessment of patients needs and how new placements would meet those. Staff used a nationally recognised risk assessment tool: 'short-term assessment of risk and treatability'. Staff had not updated patients' risk assessment and management prior to their transfer to another hospital. There was a risk that staff did not know how best to support the patient in their transition and if additional support was needed.

The provider had not ensured that they followed national standards for transfer. Managers gave us copies of the last visual discharge plans for all patients, but these did not relate to the recent transfer and new hospital placements. Information from these and patients' care plans identified that patients were ready to move to community not hospital placements. Two commissioners expressed concerns to us that the transfer to another hospital would destabilise the patient and delay the discharge plans already in place. Patients records showed provider staff had contact with commissioners previously about discharge planning and we noted commissioners had some difficulties finding an alternative community placement.

The provider had not developed a clear communication plan to notify staff about the patient transfers and closure. Most staff told us they were not satisfied about the way the transfers were communicated at short notice. Most staff did not know who and how carers, and other staff were told. Most staff did not know who made the decision to move patients to their identified placements. Most staff did not know who informed commissioners. Staff had completed discharge summaries detailing past and present care needs after patients had left the hospital.

Wards for people with learning disabilities or autism

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

Leadership

The provider had not ensured there was adequate and consistent leadership at the hospital following our last inspection in September 2019. The lack of consistent management and oversight had meant that instead of risks being managed the provider then closed the service. The CQC told the provider staff at a meeting on 11 February 2020 that they needed to have robust leadership/ management of the hospital to address the risk issues and get out of being in special measures. The CQC had placed the hospital in special measures and had taken enforcement action including issuing a fixed penalty notice on 25 June 2019 for not having a registered manager.

The provider had told us they would ensure effective management of the service. They had identified this issue on their risk register on 20 August 2019. However, the provider had not swiftly acted to manage this and instead their arrangements led to the hospital having six managers/ senior staff, three of them were new to the organisation as well as the hospital. The registered manager was unavailable from 18 December 2019 to 25 March 2020 when they applied to deregister with the CQC and left the organisation. The senior nurse/ quality assurance manager left in December 2019 and a newly employed clinical manager was appointed in November 2019.

A regional manager newly appointed on 7 October 2019 with oversight of this hospital and other locations later took over the interim hospital management. Initially the hospital was under the adult social care division of the organisation, but this changed, and the hospital then was then under the healthcare division and subsequently a new operational director.

A new regional manager (who had previously worked in another part of the organisation) took over hospital management on 17 February 2020. They submitted an application to the CQC to become the registered manager 24 March 2020. Due to the COVID-19 pandemic this was not able to be immediately processed by the CQC. Their application was terminated when the provider appointed a substantive new hospital manager who started on 4 May 2020 and the provider told us they would submit an application to become the registered manager. The new manager submitted an application to the CQC for this on 8 July 2020. The provider told us 24 June 2020 that the regional director was also being made redundant and a new regional manager at another hospital would provide some additional oversight.

The provider's leaders such as the chief executive officer and managing director had visited the hospital in February 2020. Due to COVID-19, there have been no executive or board team visits to the hospital. Hospital managers had bi monthly telephone conference calls with board of director representatives, but these were not fully effective in identifying the risks at this location. The CQC has concerns about the lack of corporate oversight of this hospital.

Culture

We were concerned about the culture at this hospital. Staff at night did not always follow the provider's policies and patients' care plans. Practices were accepted by staff rather than challenged and reported. For example, five investigation meeting minutes detailed that staff believed senior staff /managers were aware of their practice of not following patients' observation care plans. Investigation meeting minutes seen showed that clinical support worker staff had an understanding of the different level of observations in the provider's policy but had decided not to follow them.

The culture had developed as the provider's checks on staff work were limited and insufficient. There was little crossover between night and day staff as most night staff did not work in the day. There was little management or multi-disciplinary presence at night to oversee their work and ensure consistency of practice.

The provider had not ensured all staff felt respected, supported and valued. Two staff meeting minutes dated 5 December 2019 and 23 April 2020 and two supervision records showed staff had raised concerns about a bullying culture. Some staff told us they did not want to raise concerns for fear of reprisal for speaking up. There were limited actions identified by managers on how they responded to this, instead placing emphasis on staff giving managers feedback. However, hospital managers had carried out a closed culture survey with staff. Their action plan for May 2020 – May 2021 showed three of ten respondents had felt unable to raise concern about colleagues. Management actions included ensuring staff knew they could contact the speak up guardian and

arranging six weekly site visits. They arranged human resources clinics every six weeks and had plans to give staff more opportunity to speak freely within supervision sessions.

Governance

The provider's governance systems were not fully effective to assess, monitor and mitigate the risks in the hospital on an ongoing basis. Our findings from the other key questions demonstrated that governance processes had not operated effectively at team level and performance and risk were not managed well.

Staff team meeting minutes did not always capture timeframes for staff completion of actions and updates on these actions. Some staff told us the minutes had not sufficiently captured all the issues they had raised. However, minutes detailed that managers gave staff feedback from the last CQC inspection. This including the need to observe patients are per their care plan and to ensure they read the latest staff observation policy and complete training.

The provider had a monthly governance meeting. The hospital manager shared these with the corporate governance meeting. The provider had hospital managers' meeting, chaired by the operational director which discussed overarching action plans and risk registers. The hospital risk register May 2020 had identified staff observation of patients as a risk.

The provider had started in April 2020 to hold monthly regional patient safety meetings giving managers from the neighbouring Essex hospitals opportunities to meet and share information. The provider had a transition plan following a change of corporate provider to unify all of its hospitals to use one system rather than multiple systems. For example, they had new policies, information technology systems such as a new training database, an electronic patient records and incident monitoring systems.

Management of risk, issues and performance

The provider's systems for the ongoing assessment of risks to the health and safety of patients and to mitigate risks had not been adequate to identify risks of staff not observing patients as per their care plan. The systems were not robust enough to identify that a specific staff culture had developed, where a notable amount of staff disregarded the provider's observation policy and processes, particularly at nights.

The provider had not addressed and managed all risks after our September 2019 inspection. For example, relating to our imposed conditions for staff observation of patients and ensuring they had skilled, competent staff. It was only when a new substantive manager brought in from outside of the organisation came into post in May 2020 that they gave greater scrutiny and started to review closed-circuit television footage to check staff's competency in more detail. They had detected some issues with information in the staff observation competency check documents.

Provider staff told us that their internal governance systems were effective in identifying the risk that staff were not observing patients. They told us their appointment of a new manager had identified the risks. We consider that effective ongoing oversight, assessment and management of risks would have meant that they would have identified and managed any risk much earlier. Therefore there would not necessarily have resulted in transfer of patients at short notice.

Commissioners understood the provider acted in consultation with the CQC. Whereas instead it was commissioners of patients' care who informed us the afternoon of 16 June 2020 of the change of 28 days' notice to 24 to 48 hours' notice. Additionally there was no apparent risk assessment relating to transfers considering COVID-19 and national restrictions and the level of risk this could pose to patients. There was no apparent individual patient assessment considering if they or staff would be exposed to potential infection travelling to the hospital or from their admission to the hospital.

The provider's quality assurance managers weekly/ fortnightly audits to check on the provider's action plan were not fully effective to ensure the provider met the conditions imposed by the CQC. The provider did not have a robust quality assurance /scrutiny process in place to check reports and evidence sent to the CQC to show how they were meeting their conditions to the CQC. We regularly had to contact to the provider and clarify information. The CQC considered that our prompting and questioning of the provider about staff observation practice had led to the hospital managers giving greater scrutiny to staff observation of patients. Despite our regular contact with

managers, they did not initially give us sufficient information about the incident/s they detected. We had to contact them multiple times to gain more detail and clarity about details of the incidents they detected.

The provider had ensured some of the CQC imposed conditions were addressed. Staff had improved patients records to show more clearly the level of observations staff need to give patients. The provider had taken action to reduce the number of hours staff observed patients to avoid them being tired and not able to concentrate.

The hospital manager had developed a plan following the patients' transfer 18 June 2020 to help manage the changes at the hospital. This included hospital staff telephone follow up contact with patients at their new placement to give support and a plan to visit patients with the advocate to gain feedback on the matter. Stakeholders had asked the provider at a meeting 22 June 2020 for an inquiry into the transfer process to identify any learning to reduce the risks of the same situation recurring. The provider informed us they had appointed an independent agency to complete this within an initial 45 days' timeframe. The terms of reference were to be defined in collaboration with stakeholders, carers and the Care Quality Commission.

The consultant psychiatrist referred to their work of stopping over-medication of people with a learning disability, autism or both (STOMP).

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

We had identified any areas for improvement at the hospital. However, the provider has closed the hospital location and cancelled their registration for regulated activities and is no longer able to address these actions. We have included this information in our report as we consider that it is important for the reader to have information on the areas that CQC have identified as areas of improvement that would be expected from the provider had the service continued to remain registered with the Commission.

- The provider must have effective quality assurance systems for assessing and managing risk at their hospital subject to CQC enforcement or under special measures, Regulation 12 (1)(2)(a)(b)(c).
- The provider must ensure there is consistent effective leadership by a manager at their hospital appropriately registered with the Care Quality Commission to manage risk to patent's safety, Regulation 12 (1)(2)(a)(b)(c).
- The provider must implement effective checks to ensure hospital staff are observing patients as per their care plan, Regulation 12 (1)(2)(a)(b)(c).
- The provider must have an effective recruitment system to ensure that persons providing care or treatment to patients have the qualifications, competence, skills and experience to do so safely, Regulation 12 (1)(2)(a)(b)(c).
- The provider must have an effective quality assurance system to assess and monitor staff supervision and manage any risks to patients' safety, Regulation 12 (1)(2)(a)(b)(c).
- The provider must have an effective quality assurance system to assess and monitor staff appraisal and manage any risks to patients' safety, Regulation 12 (1)(2)(a)(b)(c).
- The provider must ensure that they assess and manage risk to patent's safety when transferring/ discharging them, Regulation 12 (1)(2)(a)(b)(c).
- The provider must ensure that staff inform patients of their transfer or discharge in a way that meets their individual needs, Regulation 9 Person centred care (1)(2)(3)(4)(5)(6).
- The provider must ensure all patients transfers are patient centred and in line with national best practice, Regulation 9 Person centred care (1)(2)(3)(4)(5)(6).
- The provider must involve patients, advocates, carers, commissioners and staff and in transfer/discharge plans in a timely manner, Regulation 9 Person centred care (1)(2)(3)(4)(5)(6).
- The provider must ensure they send statutory notifications to the CQC as legally required, Regulation 18, Care Quality Commission (Registration) Regulations 2009.