

Cygnnet Hospital Colchester

Quality Report

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

Ratings

Overall rating for this location

Inadequate



Are services safe?

Inadequate



Are services effective?

Inadequate



Are services caring?

Requires improvement



Are services responsive?

Good



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.

Professor Edward Baker

Chief Inspector of Hospitals

Overall summary

Our rating of this location went down. We rated it as inadequate because:

- The provider had not ensured adequate leadership for the governance systems to adequately monitor, assess, manage and mitigate risks and did not address issues of concern as identified in this report in a timely manner for Flower Adams wards. Consequently, we found risks to patients' safety had increased since our last inspection in November 2018.
- The provider's system for assessing and admitting patients was not robust to ensure adequate management and monitoring of patient risk. Staff had admitted two out of 15 patients to the service who needed a higher level of care than that which was available. This did not adhere to the provider's own admission and exclusion criteria. Staff did not assess patients adequately. They had not fully completed risk assessments on admission for six patients admitted to Flower Adams 2 ward. Admitting staff's rationale for managing patients' risks was not evident neither was their judgement on determining the level of staff observation required. Flower Adams 2 staff were not effectively implementing a daily risk assessment system designed for staff to use with patients. Agency staff and staff from other wards did not have easily accessible information to patient care and treatment records to ensure staff could easily find information to deliver care and treatment, for example to know items restricted to patients to reduce self-harm. Patients' care plans held limited details about risk issues and did not detail the level of care staff needed to give the patient.
- The provider had not ensured that staff received regular training, supervision and appraisals, and had not ensured that staff had specialist training as identified as to implement national best practice to work with patients with personality disorders. This was also identified at our 2018 inspection. The provider had not made thorough checks on agency staff to ensure they were all suitably safe or skilled to work with patients. Not all agency and permanent staff were trained in safeguarding vulnerable adults or the safe management of restraints. We checked a sample of recent observations records from 1 to 08 April 2019 and found gaps in staff's completion of records to show observation checks were taking place. We found three examples of staff using judgmental language about patients across these wards either verbally or documented in care records. Five out of 12 staff we spoke with expressed concerns about the quality of training they had received to support them in their role.
- There was insufficient staffing to maintain a safe ward environment. There were 70 occasions between

Summary of findings

January and March 2019 where there was insufficient nursing staff available on shifts. This included occasions when there was a lack of female staff to observe patients.

- The provider did not have a robust quality assurance system in place to ensure thorough investigations of incidents to identify learning and actions to be taken to prevent a reoccurrence of risks to patient safety. We checked a sample of 44 incidents investigation reports and found the terms of investigation were not always clear. They did not detail if the investigating staff member had adequate training to complete the investigation and once actions were identified, how these were audited to ensure they were completed. There were not effective systems in place to cascade learning from incidents to staff to reduce the risk of future reoccurrence. The provider had not acted swiftly to ensure suitably competent staff were deployed to carry out observation of patients. Numerous incidents had occurred when staff were allocated to observe patients. At the site visit we found gaps in staff observation records on Flower Adams 2 wards. We were not assured the provider was checking the competency and of staff and addressing the risks.
- The provider was not delivering a specialist therapeutic programme for patients with a personality disorder on these wards. The programme offered to patients was not in line with National Institute for Health and Care Excellence guidelines and the provider was not offering patients therapy recognised as best practice.
- On Flower Adams 2 wards, we identified errors relating to medication management relating to staff's prescription and administration of medication.

However:

- The provider had started to make changes to the management of the hospital. They had brought in a new operational director and a hospital director who had skills, knowledge and experience of working in or

developing personality disorder services. They had identified improvements were required for the management of the hospital and had access to extra resources.

- Senior hospital staff had started to implement governance systems to address risks such as daily 'situation report' meetings to monitor staffing needs and any shortfalls. These were not fully embedded at the time of inspection. We saw examples where they shared staff between wards or gained bank or agency staff to try and cover any shortfalls. The provider was reviewing their recruitment and retention plans to gain permanent staff.
- Staff were completing a short-term assessment of risk and treatability document or risk formulation for patients. This gave staff some information about risk histories and management of patients.
- The new hospital director had requested additional support from the provider to get the backlog of incidents investigations completed and extra staff support had been gained from outside the hospital. They had proactively reviewed historical incidents to ensure they were reported and investigated which had contributed to the backlog. The provider had developed some ways to share learning with staff. Staff displayed 'lessons learnt redtop alerts' in ward offices. This gave staff some information on how to reduce risks to patients.
- Staff ensured that patients had access to physical healthcare when needed.
- Patients could access wellbeing activities such as for mindfulness, yoga, massage, sensory integration and guided imagery techniques to assist with relaxation.
- Staff had ensured the ward environments were clean and completed regular assessments of the care environment.
- Staff said they could raise concerns about disrespectful discriminatory or abusive behaviours or attitudes towards patients without fear of the consequences.

Summary of findings

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Inadequate



Cygnet Hospital Colchester

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Long stay or rehabilitation mental health wards for working-age adults.

Summary of this inspection

Background to Cygnet Hospital Colchester

The location Cygnet Hospital Colchester is a 57-bed hospital for men and women aged 18 and above. The provider is Cygnet Learning Disabilities Ltd.

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

- Flower Adams 1 ward has nine beds for women requiring acute intensive support.

Long stay rehabilitation mental health wards for working age adults

- Flower Adams 2 has 11 beds for women requiring intensive support.
- Ramsey Unit has 21 beds for men with mental illness and complex needs requiring high intensity recovery.

Wards for people with a learning disability or autism

- Oak and Larch Courts, for men with a learning disability and associated complex needs, specifically autistic spectrum conditions requiring specialist intensive support.

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

This location is registered with the Care Quality Commission to provide the following regulated activities:

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

The registered manager (who is also the controlled drugs accountable officer) has resigned but has not de-registered with the Care Quality Commission. The provider has appointed a new hospital director who is applying to register with the Commission.

The Care Quality Commission previously carried out a comprehensive inspection of this location 13 to 14 November 2018.

Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified for:

- Regulation 9 person centred care
- Regulation 12 safe care and treatment
- Regulation 17 good governance
- Regulation 18 staffing

The provider sent the CQC their action plans to address these. However, the provider had not taken adequate action to address some areas related to these regulations. The CQC placed conditions on the location's registration and also issued a warning notice. Since this inspection of Flower Adams 1 and 2 wards, the provider has sent the CQC their action plans outlining how they will be reviewing and addressing a breach of Regulation 12, safe care and treatment relating to the conditions.

Our inspection team

The team that inspected Flower Adams wards 1 and 2 comprised of two CQC inspectors; a mental health act reviewer; two inspection managers and a specialist advisor psychologist with experience of working with patients with a personality disorder.

Summary of this inspection

Why we carried out this inspection

We carried out a focused inspection of Flower Adams wards 1 and 2 in response to a number of concerns identified by the Care Quality Commission and an outside agency in relation to the safe care and treatment of patients.

How we carried out this inspection

We carried out this inspection over three days. We inspected Flower Adams 1 and 2 wards on the 9th of April and on the 15th of April 2019 we carried out a governance review of documents relating to the running of the service onsite at the hospital. We reviewed further information sent by the provider off site in a desktop review on the 2nd May 2019. As this was a focused inspection we did not inspect all domains and key lines of enquiry.

During the inspection, the inspection team:

- visited Flower Adams 1 and 2 wards, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with three patients who were using the service;
- spoke with the hospital director and the acting managers for the wards;
- spoke with 11 other staff members who worked with the Flower Adams wards; including doctors, nurses, occupational therapist, psychologist;
- observed an episode of patient care at a therapy meeting with patients on Flower Adams 2 ward;
- attended and observed a hospital 'situation report' morning meeting;
- looked at 13 care and treatment records for patients on the Flower Adams wards;
- carried out a specific check of the medication management on Flower Adams 2 ward;
- checked 12 staff personnel files and 50 agency staff records, and
- looked at a range of policies, procedures and other documents relating to the running of the service including 44 incident investigation reports.

What people who use the service say

We spoke with three out of 15 patients across Flower Adams 1 and 2 wards. They told us that some staff were kind, respectful, compassionate and supportive and one said they felt safe and the ward was good, and they liked that the hospital did not have a smoking ban.

However, they also gave examples of where staff had not treated them well or behaved appropriately to them such as not having enough regular staff on the wards as there

could be difficulties with staff observation of them or getting a driver to take them out. Two patients said they had been hurt during staff's restraint. They said some staff did not always know how to support them.

One patient did not like the food.

As this was a focused inspection we did not contact carers. However, we had some contact from them as part of ongoing monitoring and assessment 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?

Our rating of safe stayed the same. We rated it as inadequate because:

- There were significant risks to patients' safety and others due to a lack of permanent staff who knew patients' needs and how to best deliver care and treatment. The provider had not ensured sufficient staffing for Flower Adams 1 and 2 wards. There were staffing vacancies and the provider used a lot of agency staff. Information from them for January to March 2019 showed 111 ward shifts (31%) had less nurses than required for safe care and treatment. This included occasions when there was a lack of female staff to observe patients. Ten staff and two patients said there were difficulties with staffing. The provider had not ensured that agency staff providing care or treatment to patients had the qualifications, competence, skills and experience to do so safely. The provider did not adequately check agency staff to ensure they were safe to work with vulnerable patients. Twenty one of 50 agency staff records (42%) did not detail if staff had a current disclosure and barring service check.
- The provider had not ensured that staff were adequately assessing risks for patients on admission as staff had not completed a risk assessment for six patients on Flower Adams wards. This meant there was a risk that staff would not be aware of how to best to support patients and keep them safe. The provider had not ensured that staff on Flower Adams 2 ward were effectively implementing a daily risk assessment system designed for staff to use with patients to ensure they could meet their needs. Additionally, staff were not adequately assessing risks to patients and taking actions to reduce risks at ward rounds.
- The provider had not taken adequate action to ensure that reported incidents were thoroughly investigated, and actions were taken and completed to reduce the risk of reoccurrence. We checked a sample of 44 incident investigation reports. The provider had not ensured that the terms of investigation were clear or showed that the staff member had adequate training to completing the effectively investigate. The provider was not checking that investigation reports identified adequate actions or were completed to reduce the risk of reoccurrence. The provider had a backlog of 33 reported incidents that required

Inadequate



Summary of this inspection

investigation. Additionally, the provider's systems for sharing learning from investigations with staff to improve practice and reduce further risks were not robust and we identified themes of similar incidents re-occurring.

- The provider had not ensured suitably competent staff to carry out observation of patients as they had not fully completed actions following incident investigations, for example to ensure staff (including agency) had sufficient training and competency checks. There were gaps in staff observations records on Flower Adams 2 ward. The provider had not ensured that staff had easily accessible and detailed information available to them to know what items they should restrict to reduce individual patient self harm.

However:

- Senior hospital staff had started monitoring staffing needs and any shortfalls via morning 'situation report' meetings. We saw some examples where they shared staff between wards or gained bank or agency staff to try and cover any shortfalls. The provider was reviewing their recruitment and retention plans to gain permanent staff.
- Staff were completing a short-term assessment of risk and treatability document or risk formulation for patients which gave staff some information about risks histories and management of patients.
- The new hospital director had requested additional support from the provider to ensure the backlog of incidents investigations could be completed and extra staff support had been sourced from outside the hospital. They had proactively reviewed historical incidents to ensure they were reported and investigated which had contributed to the backlog. The provider had developed some ways to share learning with staff. Staff referred to alerts and we saw 'lessons learnt redtop alerts' clearly displayed in ward offices which gave staff some information on how to reduce risks to patients.
- Staff had ensured the ward environments were clean and completed regular assessments of the care environment.

Are services effective?

Our rating of effective went down. We rated it as inadequate because:

- The provider had not ensured that staff adequately completed a comprehensive mental health assessment of five out of six Flower Adams ward 2 patients on admission. Patients' care plans reviewed were not complete and held limited details about risk issues and did not detail the level of care staff

Inadequate



Summary of this inspection

needed to give the patient. Paper files held a range of professionals' information and assessments, but these had not been fully combined in patients' care plans. Nine multi-disciplinary team 'ward round' summaries for patients held minimal assessment /review of the patient's mental health examination and care plan evidencing staff were not routinely reviewing and assessing patient's needs.

- Staff had not developed care plans with patients on Flower Adams 2 ward with clear recovery or discharge plans. Patients care plans often held repeated or generic information.
- The provider had insufficient staff with the competence, skills and experience to offer best practice and treatment to patients on these wards. Some of these concerns had previously been an issue at our 2018 inspection. Staff training records showed staff had not received specialist training such as the 'personality disorder knowledge and understanding framework' which is best practice when working with this patient group.
- The provider had not ensured that all permanent staff received regular supervision and appraisals of their work. Five out of 12 staff we spoke with expressed concerns about the amount of training they had to support them in their role. The provider was not delivering a specialist therapeutic programme for patients with a personality disorder in line with National Institute for Health and Care Excellence guidelines on Flower Adams 2 ward. The provider was not offering patients therapy recognised as best practice including regular weekly individual psychology sessions.

However:

- Staff ensured that patients had access to physical healthcare when needed.
- Patients accessed wellbeing activities such as for mindfulness, yoga, massage, sensory integration and guided imagery techniques to assist with relaxation. The provider had a recovery college offering educational courses about mental health and recovery designed to increase patients' knowledge and skills and promote self-management.
- The provider had recruited a psychologist due to start May 2019. They had arranged for an external dialectical behavioural therapy consultant to assist with embedding care models on the wards in the next few months.

Are services caring?

Our rating of caring stayed the same. We rated it as requires improvement because:

Requires improvement



Summary of this inspection

- Not all staff referred to patients on Flower Adams wards with compassion, dignity and respect. We found three examples of staff using judgemental language about patients verbally or documented in care records.
- Three patients we spoke with also gave examples of where staff had not treated them well or behaved appropriately to them.

However:

- Staff said they could raise concerns about disrespectful discriminatory or abusive behaviours or attitudes towards patients without fear of the consequences.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

As this was a focused inspection we did not inspect this domain and these key lines of enquiry

Good



Are services well-led?

Our rating of well led went down. We rated it as inadequate because:

- The provider had not ensured adequate leadership for the Flower Adams wards to reduce risks and consequently we found risks had increased for patient safety since our last inspection in November 2018. The provider had not adequately monitored, assessed, managed and mitigated risks and acted in a timely manner to address issues of concern.
- The provider had not ensured that adequate governance systems were in place. Systems had not been fully effective to ensure that there was enough staff, that staff were always trained, supervised and appraised.
- Governance to ensure staff assessed patients on admission and regularly reviewed these risks were insufficient. There was a lack of robust systems in place to investigate and learn from incidents to prevent a reoccurrence and that there was a clear therapeutic programme for patients' care and treatment based on national best practice.
- The provider's system for assessing and admitting patients was not robust as staff had admitted some patients to the service who needed a higher level of care, than was available at this location without adherence to the admission and exclusion criteria.

However:

Inadequate



Summary of this inspection

- The provider had started to make changes to the management of the hospital. They had brought in a new operational director and a hospital director who had skills, knowledge and experience of working in or developing personality disorder services. They had identified improvements were required for the management of the hospital and had access to extra resources.

Detailed findings from this inspection






Overview of ratings

Our ratings for this location are:

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

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

Inadequate 

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

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

Inadequate 

Safe and clean environment

- Staff completed regular assessments of the care environment.
- The ward layout allowed staff to observe all parts of the ward.
- Staff had managed the risk of ligature anchor points. A ligature anchor point is anything that could be used to attach a cord, rope or other material for the purpose of strangulation.
- The ward was for women only so complied with Department of Health and Social Care eliminating mixed sex accommodation guidance.
- Staff had easy access to alarms and patients had easy access to nurse call systems if necessary.
- All ward areas were clean, had good furnishings and were well-maintained.
- Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly.
- Staff adhered to infection control principles, including handwashing.
- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- Staff maintained equipment well and kept it clean.

Safe staffing

- There were significant risks to patients and others due to a lack of permanent staffing.
- The provider had calculated the baseline number and grade of nurses and support workers required on Flower Adams 1 ward to support patients. The ward's nursing staff establishment was eight nurses and 19 support workers. The provider had two qualified (25%) and five support worker staff (26%) vacancies. Ten of twelve staff and three patients we spoke with across wards referred to staffing concerns, such as difficulties with getting sufficient regular staff and using agency staff who were unfamiliar with patients' needs.
- Information from the provider January to March 2019 showed 41 ward shifts (23%) had less nurses than required for safe care and treatment.
- The provider had difficulty deploying an adequate gender mix of staff. On 18 March 2019 staff reported an incident when they only had one female staff member available instead of two to carry out observations of a patient. A male staff member was present, but they were not able to fully observe the patient in bathrooms or carry out body checks after self harm as this would affect their privacy and dignity. Information from the provider for January to March 2019, showed when there was less than 50% of female staff on duty for 42 nights and one day (24% of shifts). This posed a risk female staff may not be available to support female patients and promote dignity and privacy.
- The provider used a lot of agency staff to meet shortfalls for permanent staff. For example, on the 29 March 2019 the ward used 16% agency staff, 12 April 43% and 15 April 2019 14% usage. We checked 50 providers records for agency staff and found the provider's checks of these staff were not adequate. They had not ensured that

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

Inadequate



agency staff providing care or treatment to patients have the qualifications, competence, skills and experience to do so safely. For example, 31 records held insufficient information to ensure staff met the provider's standard for mandatory training such as infection control, manual handling and safeguarding. Ten held limited information about the staff member to show they had adequate experience to work on the ward with this patient group. We had concerns if training records were accurate as ten records (for two agencies) showed staff had completed most of their training (a mixture of classroom and e-learning) on the same day. We were, therefore, concerned that the quality of the training agency staff had received would not be of sufficient quality to ensure learning. This posed risks that staff would not know how to safely care for patients on the ward. The provider sent the CQC information in their action plans following the inspection stating they had improved their systems for checking agency staff had relevant training required to work on wards.

- The provider had not ensured staff had completed essential mandatory training to keep patients safe. Information from the provider as of 2 May 2019 showed overall 45% compliance of staff for all courses (this conflicted with another document they gave us showing 39% compliance). Sixty seven percent of staff had not completed basic life support and 'automated external defibrillation' training; 66% had not completed 'responding to emergencies e-learning' training; 63% of staff had not completed 'protecting our health and safety e-learning' and 'food safety training' and 62% had not completed 'infection control e-learning'. However, 100% of staff had completed 'fire warden/marshal training'. The provider sent the CQC information in their action plans following the inspection to show their training compliance had improved.
- After our visit the provider stated they were acting to address the concerns around agency staff and attempting to secure agency staff with suitable training and experience, for example they planned to use one agency they were satisfied could ensure adequate staff checks.
- Senior hospital staff had started monitoring staffing needs from February 2019 and any shortfalls via morning 'situation report' meetings. We saw examples

where they shared staff between wards or gained bank or agency staff to try and cover any shortfalls. The provider was reviewing their recruitment and retention plans to gain permanent /consistent staff.

- The provider employed a consultant psychiatrist and an associate specialist doctor for Flower Adams wards. Out of hours they had contracted a regular locum doctor whom staff said was accessible.

Assessing and managing risk to patients and staff

- The provider had not ensured suitably competent staff to carry out observation of patients as they had not fully completed actions following incidents, for example to ensure staff (including agency) had sufficient training and competency checks. Patients or staff had reported eight incidents between January and March 2019 where staff were asleep when allocated to closely observe patients to reduce risks. On 18 March 2019 staff left a patient they were observing to respond to an incident and the patient self-harmed. The hospital director stated that staff should only be observing patients for an hour at a time, but they were not achieving this. However, we checked a sample of observations records in April 2019 and found there were no gaps in completion.
- The provider had not ensured there were sufficiently trained staff to be able to respond to incidents of violence on the ward and, if required, carry out restraints with patients. There was a risk that patients and staff could be at risk of harm from this. Sixty five percent of permanent staff had not received recent training for this. We checked 50 agency staff records and 44 held insufficient detail to show that staff had adequate training for de-escalation and restraint as per the expectation of the provider. We checked further and 18 of these staff had been working between February and April 2019 on Flower Adams wards. Six of these staff had been interviewed by hospital managers and offered short term contracts. We found that an incident form showed one of these agency staff was involved in restraining a patient. This posed a risk of harm to both the patient and staff. We saw one incident where a patient reported they were inappropriately restrained by staff. The provider was investigating this allegation. However, information from the provider from January to March 2019 showed staff had reported 56 incidents where they had used restraint with patients. None were reported as in prone position (face down). We checked

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

Inadequate



six permanent staff's training records and found they all had received the providers training. During our visit 9 April 2019 some staff were completing the provider's de-escalation and restraints training. The hospital director was arranging for a restraint lead from one of the provider's other hospitals to offer support and training to staff onsite.

- The provider was not adequately auditing records of staff restraint with patients, as 26 of 33 (79%) staff's restraint records checked for January and March 2019 (across both wards), did not detail the names of staff involved restraining the patient. The provider would have difficulty completing any investigation of these incidents, or arranging staff debriefs in these cases.
- We checked six patients records and staff had completed a risk assessment of five patients on admission and updated them after incidents. Staff had not fully completed one patient's admission assessment and risk assessment. They had not updated another patient's care plan to reflect they posed a risk of climbing and falling. This posed a risk that staff would not be aware of how to best to support patients and keep them safe.
- The provider had implemented a daily risk assessment notes system and staff used a traffic light system (red for high risk, amber for medium and green for low risk) for staff to easily identify individually patients' risk status. Senior staff held daily 'situation report' meetings where they discussed risks for the wards and patients. Staff used a nationally recognised risk assessment tool the short-term assessment of risk and treatability (START).
- The provider had systems in place for searching patients and their bedrooms as required to reduce the risk of self harm and applied restrictions on patients' liberty only when justified. The ward did not have a seclusion room and we did not look at seclusion records and practice at this inspection. The provider could arrange for a patient's admission to a psychiatric intensive care unit if the patient required a high level of restraint in the management of violence and aggression.

Safeguarding

- The provider did not adequately check agency staff to ensure they were safe to work with vulnerable patients. Thirty one of 50 agency staff records (62%) did not give adequate information to show that that agency staff

had received training as per the provider's standard.

Twenty-one records (42%) held insufficient detail that the staff had received basic or enhanced Disclosure and Barring Service checks.

- Staff had not updated one patients' care plan following safeguarding concerns and further abuse by a patient took place.
- The provider had not ensured all staff had completed training to safeguard patients. Information from the provider as of 2 May 2019 showed all qualified staff needed safeguarding level three - adults and children at risk training. Fifty four percent of staff had not completed the provider's essential 'safeguarding individuals at risk e-learning' training. Staff we spoke with told us they had received training they had received training and gave examples of where they had reported allegations of abuse to the local authority and we saw various examples of these Staff had reported 36 safeguarding concerns from January to March 2019. Staff completed body maps after incidents of alleged physical abuse.

Staff access to essential information

- The provider did not ensure that staff had easy access to essential information. They held information about patients in various places for example in the electronic patient record and in large paper files. A new staff member would have to search in several places to find information to care for a patient. For example, risk assessments and care plans were on both electronic and paper records, but crisis and risk formulation plans were in paper folders or with staff observation records. We had identified this a risk in our July 2017 inspection.

Medicines management

- We did not check on this area for this ward.

Track record on safety

- Staff had reported 15 incidents for this ward in January 2019, including 12 for patients deliberate self-harm and seven for patients' violence. Staff had reported 41 incidents in February 2019 (23 for self-harm) and reported 61 in March 2019 (54 for self-harm).
- Staff had reported 25 incidents for this ward from 1 to 9 April 2019 and 14 related patients deliberate self-harm.

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

Inadequate



Reporting incidents and learning from when things go wrong

- The provider had not taken adequate action to ensure that reported incidents were thoroughly investigated, and actions were taken to reduce the risk of reoccurrence. We checked a sample of 10 incident investigation reports. The provider had not ensured that the terms of investigation were clear, detailed that the staff member completing the investigation had adequate training or that actions were taken to reduce the risk of reoccurrence. We checked a sample of 10 incident investigation reports. The provider had not ensured that the terms of investigation were clear, detailed that the staff member completing the investigation had adequate training or that actions were taken to reduce the risk of reoccurrence. For example, following incidents where staff were either reported to be asleep or patients had self harmed, the provider had identified that agency staff should be given their observations policy and that all staff completed a therapeutic engagement and observation competency checklist. However, we found only 10 of 50 agency staff had completed these.
- The provider had patient safety meetings for staff and folders with information across the hospital. However, there was no information for January 2019. We identified that information for February and March 2019 showed a theme relating to incidents taking place when staff were supposed to be observing patients. There was no evidence of review by the provider to see if this was an outlier for the hospital or provider and the root cause.
- Due to the number of incidents the provider had a backlog of investigations that were needed. The new hospital director had requested additional support from the provider to get these completed and extra staff support had been gained from outside the hospital. They had proactively reviewed historical incidents to ensure they were reported and investigated which had contributed to the backlog. For this ward, staff had identified some initial learning for only three out of 25 incident reports April 2019.
- The provider had developed some ways to share learning with staff. Staff referred to alerts and we saw 'lessons learnt redtop alerts' clearly displayed in ward offices for example, relating to plastic bottle seals

posing a choking risk for patients and the need to monitor items with batteries to ensure patients did not swallow them. Additionally, wards had 'lessons learnt' folders to keep information available for staff.

- Ward staff said they did not have ward team meetings but did have staff shift handovers and shared information.

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

(for example, treatment is effective)

Inadequate



Assessment of needs and planning of care

- We reviewed six patients records on this ward. Staff completed a comprehensive mental health assessment of the patient in a timely manner soon after admission.
- Staff developed care plans that met the needs identified for five of the six patients and had updated as necessary.
- Five of the six care plans were personalised.
- Staff assessed patients' physical health needs in a timely manner. However, 53% of staff had not completed 'introduction to monitoring physical health' training. This was below the provider's standard.

Best practice in treatment and care

- The provider was not delivering a specialist therapeutic programme for patients with a personality disorder on this ward. The programme offered to patients was not in line with National Institute for Health and Care Excellence guidelines, for example 'borderline personality disorder: recognition and management' [CG78] and 'post-traumatic stress disorder' [NG116]. Staff were unable to show or explain their integrated theoretical approach used by both the treatment team and the therapist or explain the psychological approach of the service and how this was shared with the patient. There was lack of information about a staged model of care.
- The provider was offering patients brief psychotherapeutic interventions which were not recommended as best practice. No patients on these wards received regular weekly individual psychology

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

Inadequate



sessions. Sessions were ad-hoc or on as requested basis. Patients could attend two psychology informed groups per week: a dialectical behavioural therapy (DBT) informed emotions group and psychoeducation group (one delivered by a psychologist, the other by an occupational therapist). These groups ran for six weeks in length. Staff were unable to show how often patients attended these groups and said attendance varied every session from three to five patients.

- Staff had not developed care plans with patients with clear recovery or discharge plans as part of managing endings and supporting transitions for patients. Patients care plans often held generic information, for example engaging 'in 25 hours of meaningful activity' but were not always specific for individual patient's needs. One referred to the patient not being ready for community engagement and did not clearly state how the patient should achieve this.
- Staff ensured that patients had access to physical healthcare when needed. The provider employed a part time physical health care nurse to provide on-site support.
- Patients could access wellbeing activities for mindfulness, yoga, massage, sensory integration and guided imagery techniques to assist with relaxation. The provider had a recovery college offering educational courses about mental health and recovery designed to increase patients' knowledge and skills and promote self-management.

Skilled staff to deliver care

- The provider did not have enough staff with the competence, skills and experience to offer best practice and treatment to patients on this ward. This was identified as a risk at our November 2018 inspection. For example, the full-time psychologist left in November 2018 and an interim lead psychologist, without specialist experience of working with this patient group, was leading the therapy programme. The provider had recruited a psychologist due to start May 2019. The hospital director said the provider had arranged for an external DBT consultant to assist with embedding care models on the wards in the next few months.
- We checked six staff records for permanently employed staff and one of six showed staff had previous relevant knowledge of working with this patient group. Training records showed staff had received some training regarding management of self harm, ligature reduction

and suicide awareness but not specialist training such as the Personality Disorder Knowledge and Understanding Framework (identified by the Department of Health and Ministry of Justice specifically to help staff working with people with personality disorders) or the personality disorders capabilities framework.

- We checked 50 agency staff records and 44 (88%) held insufficient information to show staff were skilled to work with this patient group.
- The provider had not ensured permanent and bank staff received regular supervision in accordance with the provider's policy. Data provided 2 May 2019 showed 44% of permanent staff had not received supervision as per their policy of three monthly. Eleven percent of staff had not recently received probationary supervision (where they were newly employed). The provider had not ensured permanent and bank staff received regular appraisal of their work, in accordance with the provider's policy. Data provided 2 May 2019 showed 75% of permanent staff received regular appraisals of their work. Five of 12 staff expressed concerns about the amount of training they had for their role. Three staff said staff had left/were leaving or had moved wards because of the change of patient group. However, the provider was planning to change supervision to monthly. The provider had recently set up weekly reflective practice sessions for staff to give them opportunities to gain support in how to work with this patient group, but these were not fully embedded in staff practice.
- We found examples relating to reported incidents of staff not observing patients in accordance with their care plans. Managers had suspended staff and identified an investigation was required to consider if they were competent to work on the ward or had not re-employed agency staff following concerns about their competency. However, from checking a sample of incident investigation reports and staff personnel files managers had not clearly audited action plans to ensure recommended actions such as staff training were completed. In one staff file, managers records did not clearly state if a staff member's suspension was still in effect or if they had returned to work.
- The hospital director had delivered some informal training sessions for staff; 14 staff across wards had DBT coaching skills training with plans for the remaining staff to attend. The provider had arranged some specialist

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

Inadequate 

basic training booked the week of 15 April 2019 when we visited. The provider sent the CQC information in their action plans following the inspection stating this was completed.

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

Requires improvement 

Kindness, privacy, dignity, respect, compassion and support

- Improvements were needed to ensure that staff referred to patients with compassion, dignity and respect, as we found three examples of staff using judgemental language across these wards about patients either verbally or documented in care records.
- One patient said that some staff were kind, respectful, compassionate and supportive. However, they also gave examples of where staff had not treated them well or behaved appropriately to them.
- Staff said they could raise concerns about disrespectful discriminatory or abusive behaviours or attitudes towards patients without fear of the consequences.

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

Good 

As this was a focused inspection we did not inspect this domain and key lines of enquiry.

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

Inadequate 

Leadership

- The provider had not ensured adequate leadership for these wards to reduce risks and consequently we found risks had increased for patient safety at this location since our last inspection in November 2018. We considered that a historical lack of robust leadership had caused multiple failings on the ward. In the last year the previous operational director and two registered managers/hospital directors had left the service.
- The provider had started to make changes to the management of the hospital. They had brought in a new operational director since January 2019 who visited the hospital weekly. The previous hospital director and registered manager had resigned. When we visited there was a newly appointed hospital director who was applying to the CQC to become registered. Both new directors had skills, knowledge and experience of working in or developing personality disorder services and had held leadership roles elsewhere in the organisation.
- The new hospital director had been onsite a few weeks and had identified improvements were required for the management of the hospital. They had implemented a new management structure with clear lines of accountability and were liaising with their human resources team to start making changes. They stated they had support from their line manager and from the provider to make changes to improve the service and had access to extra resources. For example, they were able to get assistance from specialist staff from another hospital regarding their governance team and restraints.
- Senior staff told us there had been opportunities to take on new roles and responsibilities, although we received mixed feedback as to the level of consultation and whether they felt suitably skilled. Staff we spoke with were positive about the changes made to the hospital's leadership roles and stated the new directors were visible and approachable. Staff said the chief operating officer had also visited the unit recently. The 'head of

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

Inadequate



care' managing these wards was covering a colleague on parental leave. They were enthusiastic about their new role. However, their previous role was working with people with a learning disability and not this specific patient group.

Governance

- The provider had not ensured that adequate governance systems were in place. Systems had not been fully effective to ensure that there was enough staff, that staff were always trained, supervised and appraised. Governance to ensure staff assessed patients on admission and regularly reviewed these risks were insufficient. There was a lack of robust systems in place to investigate and learn from incidents to prevent a reoccurrence and that there was a clear therapeutic programme for patients' care and treatment based on national best practice. However, the new hospital director had identified the current governance and management system in place was not effective and was making changes. At the time of or inspection, new management systems were not fully embedded.

Management of risk, issues and performance






- The provider had not adequately monitored, assessed, managed and mitigated risks and acted in a timely manner to address issues of concern as identified in this report. As a result, significant risks to patient safety for these wards had increased since our inspection November 2018, despite the CQC issuing requirement notices.
- For example, staff had identified risks for the wards where agency staff were reported to be asleep and not observing patients. There were two reported incidents of agency staff walking out on shift across these wards which posed risks to patients and staff on the wards. There had been occasions when patients had self harmed and the provider had not adequately reviewed their processes for checking agency staff were suitable to work on this ward.
- Staff we spoke to in November 2018 and at this visit were unclear what the focus of the two wards were. The

hospital director told us they had ensured that the wards were not full until they addressed risk areas. They told us they would look to move patients to other placements. Following our visit, the provider notified that they had temporarily stopped admitting new patients. They told us the admission criteria for the wards was being reviewed to be more thorough and effective to give staff more understanding about the difference between the two wards and also reduce the risk of inappropriate patient admissions. From 1 January to 31 March 2019 the provider had received 44 patient referrals and 15 were not accepted.

- The provider had identified three top issues on their risk register they needed to address relating to engagement and observation, staffing and hospital security. The hospital director stated this was reviewed by the operational director and the provider's senior executive team. The hospital director had introduced patient safety meetings and 'situation report' calls for staff to identify risks for wards and the hospital. The hospital director had ensured a night-time staff coordinator was in place to coordinate staff and as part of the plan to reduce risks at nights. They were also reviewing the manager on call out of hours visit requirements and checks. The new hospital director stated they had support from their line manager and from the provider to make changes to improve the service and had access to extra resources. For example, they were able to get assistance from specialist staff from another hospital such as gaining support from a Head of quality and compliance.
- The hospital director had identified a risk for the service as three administration staff had resigned as result of changes. This had an impact on being able to carry out administration tasks. They had gained additional agency administration staff resources to reduce the risks and impact.
- The provider had a system in place for staff to report risk issues and whistle blow if required and 'I need to raise a concern' information was displayed on wards.

Long stay or rehabilitation mental health wards for working age adults

Inadequate 

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

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

Inadequate 

Safe and clean environment

- Staff completed regular assessments of the care environment. The provider had notified the CQC of four incidents relating to environmental risks where patients accessed the clinic room and the staff room and gained items to harm themselves or others with. The provider had taken actions following these incidents and both areas were secure. However, the activities room still stored a lot of patients' possessions and other risk items. Although the room was locked the boxes were not secure. Staff said patients had secure lockers for restricted items and valuables.
- The ward layout allowed staff to observe all parts of the ward.
- Staff had managed the risk of ligature anchor points. A ligature anchor point is anything that could be used to attach a cord, rope or other material for the purpose of strangulation.
- The ward was for women only so complied with Department of Health and Social Care eliminating mixed sex accommodation guidance.
- Staff had easy access to alarms and patients had easy access to nurse call systems if necessary.
- All ward areas were clean, had good furnishings and were well-maintained.
- Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly.

- Staff adhered to infection control principles, including handwashing.
- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- Staff maintained equipment well and kept it clean.

Safe staffing

- There were significant risks to patients and others due to a lack of permanent staffing.
- The provider had calculated the baseline number and grade of nurses and support workers required on Flower Adams 2 ward to support patients. The ward's nursing staff establishment was eight nurses and 23 support workers. The provider had five qualified and six support worker staff vacancies at the time of the inspection.
- Ten of twelve staff and three patients we spoke with across wards referred to staffing concerns, such as difficulties with getting sufficient regular staff and using agency staff who were unfamiliar with patients' needs. Information from the provider for January to March 2019 showed 70 ward shifts (39%) had less staff than required. Staff had reported two incidents where staffing was below standards. On 16 February 2019 three staff left the ward. Staff needed to reduce their observation of a patient from being within eyesight to five-minute checks due to lack of staff. Managers gained staff from another ward to cover but one patient had self harmed and male staff had to wait until a female staff member arrived to physically check the wellbeing of the patient. The rationale for staff leaving was not reported. Another incident of short staffing was reported on 18 February 2019 between 21:00 to 01:00 hours. The provider had difficulty gaining an adequate gender mix of staff and on 9 February and 17 March 2019 staff reported an incident

Long stay or rehabilitation mental health wards for working age adults

Inadequate



when a patient self harmed in a bathroom as they had a male staff instead of female staff who did not observe them in the bathroom to protect the patient's dignity. Information from the provider for January to March 2019 showed there was less than 50% of female staff on duty over 25 nights and one day (14% of shifts). This posed a risk female staff may not be available to support patients and ensure their dignity was maintained.

- The provider used a lot of agency staff to meet shortfalls for permanent staff. For example, on 28 February 2019 the ward used 73% agency staff; 29 March 2019 the ward used 60%; 12 April 29% and 15 April 2019 30% usage. We checked 50 providers records for agency staff and found the provider's checks of these staff were not adequate. They had not ensured that agency staff providing care or treatment to patients had the qualifications, competence, skills and experience to do so safely. For example, 31 records (62%) held insufficient information to demonstrate staff met the provider's standard for mandatory training such as infection control, manual handling and safeguarding. Twenty-one records (42%) held insufficient detail that the staff had received basic or enhanced Disclosure and Barring Service. Ten held limited information about the staff member to show they had adequate experience to work with this patient group. We had concerns if training records were accurate as ten records (relating to two agencies) showed staff had completed most of their training (a mixture of classroom and e-learning) on the same day. We were, therefore, concerned that the quality of the training agency staff had received would not be of sufficient quality to ensure learning. This posed risks that staff would not know how to safely care for patients on the ward. The provider sent the CQC information in their action plans following the inspection stating they had improved their systems for checking agency staff had relevant training required to work on wards.
- The provider ensured 76% of staff had completed essential mandatory training as of 2 May 2019. However, 39% of staff had not completed 'protecting our health and safety e-learning' and 35% had not completed food safety training; 33% had not completed basic life support and 'automated external defibrillation' training and 31% had not completed 'infection control e-learning' training. All staff had completed 'fire warden/marshal training'. The provider sent us information for mandatory and compliance training which gave slightly

differing information. The provider sent the CQC information in their action plans following the inspection to show their training compliance had improved.

- After our visit the provider stated they were acting to address the concerns around agency staff and attempting to secure agency staff with suitable training and experience, for example they planned to use one agency they were satisfied could give adequate staff checks.
- Senior hospital staff had started monitoring staffing needs and any shortfalls via morning 'Situation report' meetings. We saw examples where they shared staff between wards or gained bank or agency staff to try and cover any shortfalls. The provider was reviewing their recruitment and retention plans to gain permanent /consistent staff.
- The provider employed a consultant psychiatrist associate specialist doctor for the Flower Adams wards. Out of hours they had contracted a regular locum doctor whom staff said was accessible.

Assessing and managing risk to patients and staff

- The provider had not ensured that staff were adequately assessing risks for patient on admission as staff had not completed a risk assessment for five out of six patients. For example, staff were not adequately recording their assessment of patients' risk (using the providers standard form with low, medium or high ratings) and there were gaps in records. Staff's rationale for managing patients' risks on admission was not evident and nor was their judgement on determining the level of staff observation required. This meant there was a risk that staff would not be aware of how to best to support patients and keep them safe.
- The provider had not ensured that staff were effectively implementing a daily risk assessment system designed for staff to use with patients. The provider had identified this system in their action plan following our 2018 inspection. Staff reviewed these in the morning hospital wide 'situation report' meeting for example to identify ward risks and staffing needs. We checked six patients' records and found that staff often cut and pasted entries and their current assessment of patients was not evident. Judgments for staff changing patients' risks levels were not clear for example patients were actively presenting with risk behaviours and required constant staff observation yet their rating might be recorded as

Long stay or rehabilitation mental health wards for working age adults

Inadequate 

green 'low risk'. One patient's notes gave conflicting information about the level of staff observations required. Staff reading them would not be clear about the current risks the patient presented with. The head of care managing the ward explained that staff were unsure how to use the system and there was not clear guidance on completion which had been requested.

- The provider had not ensured suitably competent staff to carry out observation of patients as they had not fully completed actions following incidents, for example to ensure staff (including agency) had sufficient training and competency checks. We checked a sample of recent observations records from 1 to 08 April 2019 and found gaps in staff's completion of records to show observation checks were taking place. For example, seven days were not signed/audited by the nurse in charge as being accurate. There were gaps in five records for hourly staff observation checks of patients and gaps in five out of six patients 15-minute observation records. Patients or staff had reported seven incidents between January and March 2019 where staff were asleep when observing patients. Staff had reported five incidents where staff were alleged not to be observing patients. Additionally, staff had reported seven incidents where patients had self harmed under staff's close observation (such as in eyesight or arm's length). The hospital director stated that staff should only be observing patients for an hour at a time, but the service were not achieving this. (We had issued a requirement notice following our 2017/18 inspection at this location).
- The provider had not ensured there were sufficiently trained staff to be able to respond to incidents of violence on the ward and if required, carry out restraints with patients. There was a risk that patients and staff could be at risk of harm. Thirty five percent of permanent and bank (as and when) staff had not received recent training for this. The providers checks showed that 28 agency staff had not received training as per their standard. We checked further and 18 of these staff had been working between February and April 2019 on Flower Adams wards. We checked 50 agency staff records and 44 (88%) held insufficient detail to show that staff had adequate training for de-escalation and restraint. Six of these staff had been interviewed by

hospital managers and offered short term contracts. We saw one incident where staff reported inappropriate an inappropriate restraint by staff, which was being investigated.

- Information from the provider showed staff had reported 43 incidents where they had used restraint with patients. The provider was not adequately auditing records of staff restraint with patients. Twenty six out of 33 restraint records checked for January and March 2019 (across both wards), did not detail the names of staff involved in restraining the patient. The provider would have difficulty completing any investigation of these incidents, or arranging staff debriefs. During our visit 9 April 2019 some staff were completing the provider's de-escalation and restraint training. The new hospital director had arranged for a staff lead for restraint from one of the providers other hospitals to offer support and training to staff onsite.
- The provider did not have robust systems in place for searching patients or their bedrooms to reduce the risk of self harm. The ward had a security nurse and their responsibilities were displayed in the ward office. However, we noted an incident where a patient gained access to a restricted item which they used to self-harm from patients' possessions which were stored in the ward activities room. We asked ward staff how new staff would know which patients they had to observe more closely to ensure they did not have access to restricted items. Staff said this information would be held in patient's crisis plans and these would be attached to staff observations records. However, we checked a sample of four and found these did not give enough information for staff and were generalised. Some information was found in other documents such as the short-term assessment of risk and treatability document or risk formulation. One patient's care plan referred to a room search but not what staff should look for. This information was often recorded in paper records and staff would need to search for this information. We were therefore concerned that essential information to manage patient risk was not easily accessible to staff.
- The ward did not have a seclusion room and we did not look at seclusion records and practice at this inspection.

Safeguarding

- The provider did not adequately check agency staff to ensure they were safe to work with vulnerable patients. Thirty one of 50 agency staff records (62%) did not give

Long stay or rehabilitation mental health wards for working age adults

Inadequate 

adequate information to show that that agency staff had received training as per the provider's standard. Eighteen agency staff records did not show staff had a current disclosure and barring service basic or enhanced check.

- The provider had not ensured all staff had completed training to safeguard patients. Information from the provider as of 2 May 2019 showed qualified staff had not completed safeguarding level 3 - adults and children at risk' training. However, 78% of staff had completed 'safeguarding individuals at risk e-learning' training. Staff stated they had received training and gave examples of where they had reported allegations of abuse to the local authority. We saw various examples of these. Staff we spoke to told us they completed body maps after incidents of alleged physical abuse.
- Staff had reported 62 safeguarding concerns from January to March 2019.

Staff access to essential information

- The provider did not ensure that staff had easy access to essential information. They held information about patients in various places for example in the electronic patient record and in large paper files. A new staff member would have to search in several places to find information to care for a patient. For example, we had difficulty finding information about patients on this ward as risk assessments and care plans were on both electronic and paper records, but crisis and risk formulation plans were in paper folders or with staff observation records. We had identified this risk for the provider in our July 2017 inspection of the hospital.

Medicines management

- We checked medicines management for this ward as two incidents of errors with medication were reported. We checked six patients' medication charts and identified that improvements were needed. We found the provider had some protocols for staff to administer 'prn' (only as needed) medication. However, one patient was being prescribed medication by injection almost daily despite having a care plan to discontinue this and staff did not have a protocol for guidance. Staff had written two prescription entries for the same medication for a patient. This could pose a risk that the patient

received their medication twice. There was no evidence staff had given additional medication. On one card the medication dosage had increased but staff were giving the previously prescribed lower dose.

- The provider had set up a contract with a local pharmacy service to support them with audits (not seen). We saw some examples of staff following National Institute for Health and Care Excellence guidance when using rapid tranquilisation medication with patients.

Track record on safety

- Staff had reported 35 incidents for this ward in January 2019, including 22 for patients' deliberate self-harm and seven for patients' violence. Staff had reported 70 incidents in February 2019 (32 for self-harm and 28 violence) and reported 53 in March 2019 (34 for self-harm and eight for violence).

Reporting incidents and learning from when things go wrong

- The provider had not taken adequate action to ensure that reported incidents were thoroughly investigated, and actions were taken to reduce the risk of reoccurrence.
- We checked a sample of 34 incident investigation reports. The provider had not ensured that the terms of investigation were clear, detailed that the staff member completing the investigation had adequate training or that actions were taken to reduce the risk of reoccurrence. We checked a sample of 10 incident investigation reports. The provider had not ensured that the terms of investigation were clear, detailed that the staff member completing the investigation had adequate training or that actions were taken to reduce the risk of reoccurrence. For example, following incidents where staff were either reported to be asleep or patients had self harmed, the provider had identified that agency staff should be given their observations policy and that all staff completed a therapeutic engagement and observation competency checklist. However, we found only 10 of 50 agency staff (20%) had completed these.
- The provider had patient safety meetings for staff and folders with information across the hospital. However, there was no information for January 2019. We identified information for February and March 2019 showed a theme relating to incidents taking place when

Long stay or rehabilitation mental health wards for working age adults

Inadequate



staff were due to observe patients. There was no apparent review of this by the provider to see if this was an outlier for the hospital or provider and the root cause.

- Due to the number of incidents the provider had a backlog of incidents requiring investigation. The new hospital director had requested additional support from the provider to complete these and extra staff support had been sourced from outside the hospital. They had proactively reviewed historical incidents to ensure they were reported and investigated which had contributed to the backlog. For this ward, staff had identified some initial learning for only three out of 25 incident reports in April 2019 and some reports were difficult to read. We found two examples of incidents forms referring to other incidents on the ward for February 2019 and one in April 2019, but the other incident report was not found, therefore would not be investigated. We saw examples of minutes for three debrief meetings for staff and for three incidents. We checked this against the original incident reports and it was not clear how the debrief related to incident.
- The provider had developed some ways to share learning with staff. Staff referred to alerts and we saw 'lessons learnt redtop alerts' clearly displayed in ward offices, for example relating to plastic bottle seals posing a choking risk for patients and the need to monitor items with batteries to ensure patients did not swallow them. Additionally, wards had 'lessons learnt' folders to keep information available for staff.
- Ward staff said they did not have ward team meetings but did have staff shift handovers and shared information. However, handover records seen for April 2019 did not show this.

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

(for example, treatment is effective)

Inadequate



Assessment of needs and planning of care

- The provider had not ensured that staff completed a thorough assessment and care plans for five out of six patients records we reviewed on this ward. Staff had not

adequately completed a comprehensive mental health assessment of the patient on admission. We have reported in more detail about this under the safe domain. The provider's document held limited space for staff to record information with a predominant focus on physical health needs.

- Staff had developed care plans for patients. However, in five out of six records we found these did not fully reflect the patients' needs. For example, a safeguarding concern was reported for one patient but not detailed in a care plan. Staff had not updated another patient's care plan. Other patients' care plans held limited details about risk issues and did not detail the level of care staff needed to give the patient. Paper files held a range of professionals' information and assessments, but these had not been fully combined in patients' care plans.
- We checked nine multi-disciplinary team 'ward round' summaries for patients Staff's records were not available in one patient's paper file. These held minimal assessment or review of the patient's mental health examination and care plan.
- Staff had assessed patients' physical health needs. Staff had offered patients a self-assessment form on admission to gain their views about their needs.

Best practice in treatment and care

- The provider was not delivering a specialist therapeutic programme for patients with a personality disorder on these wards. The programme offered to patients was not in line with National Institute for Health and Care Excellence guidelines, for example 'borderline personality disorder: recognition and management' [CG78] and 'post-traumatic stress disorder' [NG116]. Staff were unable to show us or explain the integrated theoretical approach used by both the treatment team and the therapist or explain the psychological approach of the service and how this was shared with the patient. There was lack of information about a staged model of care for example care planning information did not capture staff's assessment of patients' motivation to change and the intervention or support they would give to help them get toward a pre-therapy stage and rehabilitation.
- The provider was offering patients brief psychotherapeutic interventions which were not recommended as best practice. No patients on these wards received regular weekly individual psychology sessions. Sessions were ad-hoc or on 'as requested'

Long stay or rehabilitation mental health wards for working age adults

Inadequate 

basis. Patients could attend two psychology informed groups per week dialectical behavioural therapy informed emotions group and psychoeducation group (one delivered by a psychologist, the other by an occupational therapist). These groups ran for six weeks in length. Staff were unable to show how often patients attended these groups and said attendance varied every session from three to five patients.

- The provider was not offering patients therapy recognised as best practice such as dialectical behavioural therapy (for women with borderline personality disorder to assist with reducing recurrent self-harm), eye movement desensitization and reprocessing (a form of psychotherapy), narrative therapy or trauma focused cognitive behavioural therapy as recognised in the National Institute for Health and Care Excellence guidelines for post-traumatic stress disorder. Three patients' records identified that patients had trauma related symptoms.
- Staff had not developed care plans with patients with clear recovery or discharge plans as part of managing endings and supporting transitions for patients. For example, patients care plans often held generic information for example, such as engaging 'in 25 hours of meaningful activity' but were not always specific for individual patient's needs. One referred to the patient not being ready for community engagement and did not clearly state how the patient should achieve this.
- Staff ensured that patients had access to physical healthcare when needed. The provider employed a part time physical health care nurse to provide on-site support.
- Patients could access wellbeing activities such as for mindfulness, yoga, massage, sensory integration and guided imagery techniques to assist with relaxation. The provider had a recovery college offering educational courses about mental health and recovery designed to increase patients' knowledge and skills and promote self-management.

Skilled staff to deliver care

- The provider did not have enough staff with the competence, skills and experience to offer best practice and treatment to patients on this ward. This was identified at our November 2018 inspection and we told the provider to take actions to address the risk. For example, the full-time psychologist left in November 2018 and an interim lead psychologist, without

specialist experience of working with this patient group, was leading the therapy programme. The provider had recruited a psychologist due to start May 2019. The hospital director said the provider had arranged for an external DBT consultant to assist with embedding care models on the wards in the next few months.

- We checked six staff records for permanently employed staff and only one of six showed staff had previous relevant knowledge of working with this patient group. Training records showed staff had received some training regarding management of self harm, ligature reduction and suicide awareness but not specialist' training such as the 'personality disorder knowledge and understanding framework (identified by the Department of Health and Ministry of Justice, specifically to help staff working with people with personality disorders,) or the personality disorders capabilities framework.
- We checked 50 agency staff records and 44 (88%) held insufficient information to show staff were skilled to work with this patient group.
- The provider had not ensured that permanent and bank staff were in receipt of regular appraisals of their work. Data provided in May 2019 showed 91% of permanent staff had not received an appraisal of their work. Five of 12 staff across wards expressed concerns about the amount of training they had for their role. Three staff said staff had left/were leaving or had moved wards because of the change of patient group.
- We found examples relating to reported incidents of staff not observing patients, where managers had suspended staff and identified an investigation was required to consider if they were competent to work on the ward or had not re-employed agency staff following concerns about their competency. However, from checking a sample of incident investigation reports and staff personnel files managers had not clearly audited action plans to ensure recommended actions such as staff training were completed. In one staff file managers records did not clearly state if a staff member's suspension was still in effect or if they had returned to work.
- The hospital director had delivered some informal training sessions for staff. Fourteen staff across wards had DBT coaching skills training with plans for the remaining staff to attend. The provider had arranged

Long stay or rehabilitation mental health wards for working age adults

Inadequate 

some specialist basic training booked the week of 15 April and again in May 2019. The provider sent the CQC information in their action plans following the inspection stating this was completed.

- The provider had ensured that 90% of permanent staff received supervision as per their policy of three monthly (as of 2 May 2019) and 67% of staff had received probationary supervision. The provider planned to offer staff supervision monthly. The provider had recently set up weekly reflective practice sessions for staff to give them opportunities to gain support in how to work with this patient group.

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

Requires improvement 

Kindness, privacy, dignity, respect, compassion and support

- Improvements were needed to ensure that staff referred to patients with compassion, dignity and respect, as we found three examples of staff using judgemental language about patients across these wards about patients either verbally or documented in records.
- Two patients said that some staff were kind, respectful, compassionate and supportive. However, they also gave examples of where staff had not treated them well or behaved appropriately to them. During our visit we observed staff were respectful and supportive when interacting with patients in a morning therapy meeting on Flower Adams 2 ward.
- Staff said they could raise concerns about disrespectful discriminatory or abusive behaviours or attitudes towards patients without fear of the consequences.

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

Good 

As this was a focused inspection we did not inspect this domain and key lines of enquiry.

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

Inadequate 

Leadership

- The provider had not ensured adequate leadership for these wards to reduce risks and consequently we found risks had increased for patient safety at this location since our last inspection in November 2018. We considered that a historical lack of robust leadership had caused multiple failings on the ward. In the last year the previous operational director and two registered managers/hospital directors had left the service.
- The provider had started to make changes to the management of the hospital. They had brought in a new operational director since January 2019 who visited the hospital weekly. The previous hospital director and registered manager had resigned. When we visited there was a newly appointed hospital director who was applying to the CQC to become registered. Both new directors had skills, knowledge and experience of working in or developing personality disorder services and had held leadership roles elsewhere in the organisation.
- The new hospital director had been onsite a few weeks and had identified improvements were required for the management of the hospital. They had implemented a new management structure with clear lines of accountability and were liaising with their human resources team to start making changes.
- Senior staff told us there had been opportunities to take on new roles and responsibilities, although we received

Long stay or rehabilitation mental health wards for working age adults

Inadequate 

mixed feedback as to the level of consultation and whether and they felt suitably skilled. Staff we spoke with were positive about the changes made to the hospital's leadership roles and stated the new directors were visible and approachable. Staff said the chief operating officer had also visited the unit recently. The 'head of care' managing these wards was covering a colleague on parental leave. They were enthusiastic about their new role. However, their previous role was working with people with a learning disability and not this specific patient group.

Governance

- The provider had not ensured that adequate governance systems were in place. Systems had not been fully effective to ensure that there was enough staff, that staff were always trained, supervised and appraised. Governance to ensure staff assessed patients on admission and regularly reviewed these risks were insufficient. There was a lack of robust systems in place to investigate and learn from incidents to prevent a reoccurrence and that there was a clear therapeutic programme for patients' care and treatment based on national best practice. However, the new hospital director had identified the current governance and management system in place was not effective and had started to make changes. At the time of or inspection, new management systems were not fully embedded.

Management of risk, issues and performance

- The provider had not adequately monitored, assessed, managed and mitigated risks and acted in a timely manner to address issues of concern as identified in this report. As a result, significant risks to patient safety for these wards had increased since our inspection November 2018, despite the CQC issuing requirement notices.
- For example, staff had identified risks for the wards where agency staff were reported to be asleep and not observing patients. There were two reported incidents of agency staff walking out on shift across these wards which posed risks to patients and staff on the wards. There had been occasions when patients had self harmed and the provider had not adequately reviewed their processes for checking agency staff were suitable to work on this ward.
- During our visit we also found staff had previously not adhered to the provider's admission and exclusion

criteria. For example, two of 15 patients admitted to Flower Adams 2 ward required enhanced level of staff observations and required as needed medication on a regular basis. Staff we spoke to in November 2018 and at this visit were unclear what the focus of the two wards were. The hospital director told us they had ensured that the wards were not full until they addressed risk areas. They told us they would look to move patients to other placements. Following our visit, the provider notified that they had temporarily stopped admitting new patients. They told us the admission criteria for the wards was being reviewed to be more thorough and effective to give staff more understanding about the difference between the two wards and also reduce the risk of inappropriate patient admissions. They had identified some patients who had been inappropriately admitted who needed a higher level of care which they were addressing. From 1 January to 31 March 2019 the provider had received 44 patient referrals and 15 were not accepted.






- The provider had identified three top issues on their risk register they needed to address relating to engagement and observation, staffing and hospital security. The hospital director stated this was reviewed by the operational director and the provider's senior executive team. The hospital director had introduced patient safety meetings and 'situation report' calls for staff to identify risks for wards and the hospital. However, these would not be fully effective for example as staff on Flower Adams 2 ward were ensure how to complete daily risks assessments for patients. The hospital director had ensured a night-time staff coordinator was in place to coordinate staff and as part of the plan to reduce risks at nights. They were also reviewing the manager on call out of hours visit requirements and checks. The new hospital director stated they had support from their line manager and from the provider to make changes to improve the service and had access to extra resources. For example, they were able to get assistance from specialist staff from another hospital such as gaining support from a Head of quality and compliance.
- The hospital director had identified a risk for the service as three administration staff had resigned as result of changes. This had an impact on being able to carry out administration tasks. They had gained additional agency administration staff resources to reduce the risks and impact.

Long stay or rehabilitation mental health wards for working age adults

Inadequate 

- The provider had a system in place for staff to report risk issues and whistle blow if required and 'I need to raise a concern' information was displayed on wards.

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Inadequate 

Start here...

Are wards for people with learning disabilities or autism effective?
(for example, treatment is effective)

Requires improvement 

Start here...

Are wards for people with learning disabilities or autism caring?

Requires improvement 

Start here...

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

Good 

Start here...

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

Requires improvement 

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must carry out reassessment of risks and needs of existing patients and develop care and risk management plans.
- The provider must ensure adequate governance systems are in place to monitor, assess, manage and mitigate risks and act in a timely manner to address issues of concern for patient safety.
- The provider must ensure adequate leadership to reduce risks for patient safety at this location.
- The provider must implement an appropriate system to ensure that thorough incident investigations take place in a timely manner.
- The provider must have a robust system to share all learning from incident investigations and actions with staff.
- The provider must have an adequate system to ensure incident investigation actions are completed to prevent the risk of reoccurrence.
- The provider must ensure that wards are staffed with the required numbers of staff to meet patients' needs and to undertake patient observations including adequate gender mix.
- The provider must ensure that staff have the qualifications, skills and experience required to work with this patient group.
- The provider must ensure that all agency staff have received adequate checks and checks to ensure they have essential training, experience to work with the patient group including disclosure and barring service checks.

- The provider must ensure all permanent staff have received specialist training at the required level in line with national best practice.
- The provider must review their admission and exclusion criteria to ensure staff have clear information to understand which patients are suitable for the service and embed in practice.
- The provider must ensure a specialist therapeutic programme for patients with a personality disorder on these wards in line with best practice.
- The provider must ensure staff receive regular supervision for their work.
- The provider must ensure staff receive regular appraisal of their work.
- The provider must ensure all staff have received the training required by the provider's standard.
- The provider must ensure their patient care and treatments records are easily accessible, so staff can easily find information to deliver care and treatment.
- The provider must ensure adequate checks to reduce risks for staff's prescription and administration of medication to patients on Flower Adams 2 ward.
- The provider must ensure staff complete and audit records of restraint with patients.
- The provider must ensure staff treat patients with dignity and respect including in all forms of documentation.

Action the provider **SHOULD** take to improve

- The provider should review their recruitment processes to ensure permanent staff are suitable to work on the wards and have the qualifications, skills and experience required.

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 10 HSCA (RA) Regulations 2014 Dignity and respect The provider had not ensured staff always referred to patients with dignity and respect. This was a breach of Regulation 10 (1).
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 The provider had not ensured that patient's care and treatments records were easily accessible, so staff could easily find information to deliver care and treatment. The provider had not ensured adequate checks to reduce risks for staff's prescription and administration of medication to patients on Flower Adams 2 ward. The provider had not ensured staff completed and audited records of restraint with patients. This was a breach of Regulation 12 (1)(2)(b)(g)

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The provider had not ensured adequate leadership to reduce risks for patient safety at this location.</p> <p>The provider had not ensured adequate governance systems were in place to monitor, assess, manage and mitigate risks and act in a timely manner to address issues of concern for patient safety.</p> <p>The provider had not ensured staff followed and understood their admission and exclusion criteria.</p> <p>The provider had not ensured a specialist therapeutic programme for patients with a personality disorder on these wards in line with best practice.</p> <p>The provider had not ensured staff received regular supervision for their work.</p> <p>The provider had not ensured staff received regular appraisal of their work.</p> <p>The provider had not ensured all staff had received the training required by the provider's standard.</p> <p>This was a breach of Regulation 17 (1) (2) (a) (b) (c)(d) (f).</p>
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The provider had not ensured all patients risks and needs were assessed.</p> <p>The provider did not have an appropriate system to ensure that thorough incident investigations take place in a timely manner.</p>

Enforcement actions

The provider had not ensured a system to share learning from incident investigations or actions with staff.

The provider had not ensured adequate systems to ensure actions from investigations were completed to prevent the risk of reoccurrence.

The provider had not ensured wards were staffed with the required numbers of staff to meet patient's needs and to undertake patient observations including adequate gender mix.

The provider had not ensured that staff had the qualifications, skills and experience required to work with this patient group.

The provider had not ensured that all agency staff have received adequate checks and checks to ensure they have essential training, experience to work with the patient group including disclosure and barring service checks.

The provider had not ensured all permanent staff received specialist training at the required level in line with national best practice.

This was a breach of Regulation 12 (1)(2)(a)(b)(c).