

Cygnet Learning Disabilities Midlands Limited

Cygnet Views

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Requires Improvement



Are services safe?

Requires Improvement



Are services effective?

Requires Improvement



Are services caring?

Requires Improvement



Are services responsive to people's needs?

Requires Improvement



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found

The service was not able to show how they met some of the principles of right support, right care, right culture all the time.

Right Support

The Model of Care and treatment setting maximised people's choice, control and independence for people who were settled. It prepared people to take the final steps of their rehabilitation before going to community placements. However, the Model of care and setting did not meet the needs of people who were also experiencing acute mental ill health or people with limited mobility. Staff were clear that if a person with limited mobility was referred to the service, they would not be able to meet their needs. Managers accepted that this would limit their quality of life as they would find it difficult to access the garden and the cobbled stones in the car park would limit their opportunity to use the salon and access the meeting room.

People told us staff supported them to take part in activities and to pursue their interests in their local area when the hospital was settled. One person said they liked to go out for walks and could go out when they wanted to with staff. People had opportunities to use local facilities for learning, education, and voluntary work. Permanent staff supported people whenever possible to play an active role in maintaining their own health and wellbeing. Staff gave people information about accessing well woman checks and supported people to attend these. The service provided care and support in a safe, clean, and well-furnished, environment. Although space was limited, the service prided itself on providing a homely environment in which people could develop their skills and knowledge, to help them move onto community settings. However, some people said they did not always know staff because they did not wear clear name badges and there was no photo board of staff they could refer to.

Right Care

Care is person-centred and promotes people's dignity, privacy, and human rights. However, not all staff knew of, or understood all people's care needs. Some staff did not always meet the individual care needs identified or treated people in a way that encouraged them to achieve their potential. While care plans were person centred and showed people's goals for treatment and hopes for their future not all staff were following the care plans, risk management plans or positive behavioural support plans. Risk management plans, while appropriate for the person they were intended for, did not always consider the impact they would have on other people using the service.

The service worked well with other agencies such as the local authority and the police to manage safeguarding. They had worked hard to strengthen their links with their Integrated Care Board. Staff had training on how to recognise and report abuse and they knew how to apply it.

Summary of findings

Right Culture

The ethos, values, attitudes and behaviours of leaders and most care staff ensured people using services led confident, inclusive, and empowered lives. Most staff placed people's wishes, needs, and rights at the heart of everything they did. The registered manager and all staff understood the importance of family to people. However, one relative said communication could be better, they were unable to attend their relative's last review and did not receive notes from it. However, another relative told us that because they lived a long way away and did not drive the provider had paid for them to travel to Matlock and stay overnight so they could see their relative. The relative also told us the doctor rearranged their relative's care and treatment review to coincide with their visit, so they could be present. People, and those important to them, were involved in planning their care. People said they liked going out but due to the remote location many outings had to be completed using the hospital minibus. One person thought having the hospital minibus was a good thing as they could go further afield with their friends and in safety. People's quality of life was enhanced by the service's culture of improvement and inclusivity.

The service had policies and systems in place to support people in the least restrictive way. Although staff used these to support people who had acute mental health needs, the restrictive practices negatively impacted on other people who did not have these needs. However, leaders in the service had worked hard to create a learning culture. Most permanent staff we spoke with said they felt valued and empowered to suggest improvements and question poor practice. There was a transparent, open, and honest culture between people, those important to them, staff, and leaders. They all felt confident to raise concerns and complaints.

SUMMARY

Our rating of this service went down. We rated it as requires improvement because:

Not all temporary staff knew the people they were looking after, this prevented staff from interacting with people in a way that encouraged people to achieve their potential and ensure all people's individual needs were met.

People using the service did not always know who the staff were. Staff did not wear clear name badges and there was no staff photograph board in the communal area. This could have prevented people from feeling comfortable enough around staff to exercise their autonomy.

People could not always access support from independent advocacy. The advocate was not able to be in the communal areas when people were distressed.

Some staff were not always aware of individual risk. Some support staff were not always following individual risk management plans. While risk management plans were adequate for the person they were intended for, they did not always consider the impact of a person's actions on other people and visitors.

There was no evidence to show how staff monitored people's physical health if the person declined physical observations. We reviewed two people's records; one person was on high dose anti-psychotic medicine and the other person required intra-muscular rapid tranquilisation.

Staff were not always following handwashing procedures. There was risk of cross contamination from people's laundry. Staff had not separated out people's laundry and there was no process for keeping dirty laundry separate from clean laundry.

Summary of findings

Staff had not cleaned the splashback around the sink in the therapy kitchen. Staff had not cleaned a medicines trolley or inside a clinic room cupboard properly.

Due to the design and layout of the hospital the environment was not suitable for people who were experiencing acute mental ill health or who had a history of using ligatures. Staff could not control the heating in the communal areas of the hospital. On the day of our inspection the communal areas were uncomfortably hot.

Although audits and governance were in place some of the systems and processes had not been used to full effect.

Apart from the new manager and new Head of Care the registered nurses did not have a learning disability background. Registered nurses were not always present in communal areas and were not providing leadership or positive role modelling for healthcare support workers.

Managers were not monitoring support staff's competency or understanding following completion of their online learning disability training. Therefore, some staff were not always confident when working with people with a learning disability and autistic people.

The admission policy did not identify what measures should be in place if a newly admitted person was later found to be too acute for the service to manage safely. Due to its design and layout the hospital environment was not suitable for acutely unwell people. We judged that the provider should address this issue.

Staff did not always follow the new protocol for administering medicines 'when needed'. We judged that the provider should address this issue. Staff had not ensured that the glucose monitors taken in by people using the service were all calibrated.

However:

There was a full multidisciplinary team of staff working in the hospital. Their specialist assessments were thorough and comprehensive.

Information about people who use the service was easily accessible in both electronic and hard copy format. Positive behaviour support plans, and risk management plans were available in easy read and grab sheet format.

There were enough staff to meet people's needs.


Although the registered manager and new Head of Care were new to the service, having only been in post five weeks, both were experienced in hospital management and caring for people with learning disability and autistic people.

Managers at the hospital were responsive and keen to learn from our inspection findings. Within two weeks of our onsite visit, they had already sent an action plan and evidence of having addressed the issues we raised in our initial feedback.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
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Wards for people with learning disabilities or autism	Requires Improvement 	
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Summary of findings

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Summary of this inspection

Background to Cygnet Views

About the service

Cygnet Views is an independent hospital managed by Cygnet Learning Disabilities Midlands Limited.

Cygnet Views registered with the Care Quality Commission for the following regulated activities:

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

The hospital provides care for up to 10 women who have a learning disability or autism and complex mental health needs. At the time of inspection, the service was supporting 7 people, one person was using two bedrooms to support her needs.

The service has a registered manager and accountable drugs officer.

We carried out this unannounced, comprehensive inspection following receipt of 2 serious incident notifications: 1 whistleblowing report and a further 6 notifications relating to one person. After discussions with the provider and the local Integrated Care Board we held a desk top review of the information we had received over the previous three months. Our conclusion indicated we should carry out onsite inspection due to potential increase in risk to people.

What people who use the service say

We spoke with 3 people using the service, and 2 of their family members. We reviewed the people's individual satisfaction survey dated February 2022.

People's opinions about Cygnet Views hospital were mixed.

Person 1 told us that she gets frightened when other people start shouting. She said she had not been at the hospital very long but did not get a proper introduction to other people. She could not remember where rooms were, and no one had taken her around the hospital since the first day. She said she was not sure what she should be doing and did not know what her timetable was going to be, because she had only met someone the previous day who had asked her what she liked doing. She also told us that she had already been disappointed when staff had needed to cancel a visit with her mother the previous day because another person was upset, and staff told her it was not safe for visitors to be in the hospital. She had not been there long enough to have any section 17 leave from the hospital to meet her mother off site. However, she told us that staff had helped her to stay connected with family and friends using her mobile phone. She was pleased and thought this was good because she had not been allowed to keep her phone with her all the time at her previous placement.

Person 2 told us that she thought it was OK at the hospital unless other people got upset. She said the staff had paid for her family to visit her at Views and because they lived a long way from the hospital, they provided hotel accommodation so they could stay over. She told us that most of the regular staff were OK but temporary staff were not good. She said that they never introduced themselves properly and did not do what they should be doing, they just sat watching them (the people using the service) or using their mobile phones.

Summary of this inspection

Person 3 told us she was not happy at the hospital. The temporary staff did not always talk to them (the people using the service). She said there never seemed to be enough staff when she wanted to go off the hospital grounds even though her section 17 leave allowed her to do this with staff escort. She thought this was because so many of them were looking after some of the other more unwell people. She also said she did not think staff encouraged her enough to do what was on her timetable and if she said no to doing something they just left her to get bored. She added that if they tried to encourage her to do things then she would do them.

Family member 1 told us that her daughter's care was excellent – she had settled at the hospital and was doing well. She felt staff enabled her daughter to make choices, they knew she could not process a lot of information at any one time and so gave her a choice of 2 or 3 options for each decision. She said she had been involved in her daughter's discharge planning and when the doctor had changed her daughter's medication he explained why.

Family member 2 told us that she did not think staff could manage all the people at the hospital and her daughter was afraid of a recently admitted person who was not nice to her. Staff did not seem to know what to do with the person or how to stop the other person being nasty to her daughter. She also told us that on a few occasions she had visited her daughter at the hospital there had not been a lot going on and people often just sat around saying they were bored.

How we carried out this inspection

This inspection was an unannounced, comprehensive inspection.

We were on site for one day, telephone interviews with staff and analysis of data and information sent to us by the provider was reviewed in the week following inspection.

Our inspection team comprised two inspectors and a specialist advisor nurse. An expert by experience carried out face to face interviews with people using the service and telephone interviews with family members.

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

During this inspection, the inspection team:

spoke with 3 people in the service,

spoke with 14 members of staff including a doctor, maintenance staff, occupational therapist, psychologists, registered nurses, and support workers,

interviewed the registered manager,

looked at the quality of the hospital environment, including communal areas and the clinic,

looked at 4 peoples' care and treatment records in detail,

looked at 7 people's medicine records

spoke with 2 family members of people who used the service,

Summary of this inspection

observed peoples' care,

attended one nurse handover,

spoke with the advocate,

looked at other documentation and records related to peoples' care and overall governance of the service.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

How we carried out this inspection

SUMMARY

Our rating of this service went down. We rated it as requires improvement because:

Not all temporary staff knew the people they were looking after, this prevented staff from interacting with people in a way that encouraged people to achieve their potential and ensure all peoples individual needs were met.

People using the service did not always know who the staff were. Staff did not wear clear name badges and there was no staff photograph board in the communal area. This could have prevented people from feeling comfortable enough around staff to exercise their autonomy.

People could not always access support from independent advocacy. The advocate was not able to be in the communal areas when people were distressed.

Some staff were not always aware of individual risk. Some support staff were not always following individual risk management plans. While risk management plans were adequate for the person they were intended for, they did not always consider the impact of a person's actions on other people and visitors.

There was no evidence to show how staff monitored people's physical health if the person declined physical observations. We reviewed two people's records; one person was on high dose anti-psychotic medicine and the other person required intra-muscular rapid tranquilisation.

Staff were not always following handwashing procedures. There was risk of cross contamination from people's laundry. Staff had not separated out people's laundry and there no process for keeping dirty laundry separate from clean laundry.

Staff had not cleaned the splashback around the sink in the therapy kitchen. Staff had not cleaned a medicines trolley or inside a clinic room cupboard properly.

Due to the design and layout of the hospital the environment was not suitable for people who were experiencing acute mental ill health or who had a history of using ligatures. Staff could not control the heating in the communal areas of the hospital. On the day of our inspection the communal areas were uncomfortably hot.

Summary of this inspection

Although audits and governance were in place some of the systems and processes had not been used to full effect.

Apart from the new manager and new Head of Care the registered nurses did not have a learning disability background. Registered nurses were not always present in communal areas and were not providing leadership or positive role modelling for healthcare support workers.

Managers were not monitoring support staff's competency or understanding following completion of their online learning disability training. Therefore, some staff were not always confident when working with people with a learning disability and autistic people.

The admission policy did not identify what measures should be in place if a newly admitted person was later found to be too acute for the service to manage safely. Due to its design and layout the hospital environment was not suitable for acutely unwell people. We judged that the provider should address this issue.

Staff did not always follow the new protocol for administering medicines 'when needed'. We judged that the provider should address this issue. Staff had not ensured that the glucose monitors taken in by people using the service were all calibrated.

However:

There was a full multidisciplinary team of staff working in the hospital. Their specialist assessments were thorough and comprehensive.

Information about people who use the service was easily accessible in both electronic and hard copy format. Positive behaviour support plans, and risk management plans were available in easy read and grab sheet format.

There were enough staff to meet people's needs.

Although the registered manager and new Head of Care were new to the service, having only been in post five weeks, both were experienced in hospital management and caring for people with learning disability and autistic people.

Managers at the hospital were responsive and keen to learn from our inspection findings. Within two weeks of our onsite visit, they had already sent an action plan and evidence of having addressed the issues we raised in our initial feedback. One week after our visit management decided to voluntarily stop any further admissions so they could address the issues we found on inspection.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the provider MUST take to improve:

We told the service that it must take action to bring services into line with five legal requirements. This action related to one service.

Summary of this inspection

- The provider must ensure that all staff know the people they are looking after and ensure that staff are engaging with people in a way that encourages people to achieve their potential and ensure all their individual needs were met. Regulation 10(1)
- The provider must ensure that all staff wear clearly identifiable name badges and introduce themselves to people. The provider must ensure that there is a staff identity board in the main communal area of the hospital. Regulation 10(1)
- The provider must ensure that the advocate is able to have access to all people in the communal areas as well as in private while she is on the unit. Regulation 10(1)
- The provider must ensure that all staff are aware of everyone's risk management plan the provider must make sure that the actions required to manage a person's risk does not have negative impact on other people in the service. Regulation 12(1)
- The provider must ensure that staff are recording how they are checking people's physical health, when the person has declined physical observations. Regulation 12(1)
- The provider must ensure that all staff follow handwashing procedures all the time. The provider must ensure that staff follow all cleaning procedures all the time. The provider must ensure that all staff are aware of how to keep peoples laundry separated. Regulation 12(1)
- The provider must ensure that staff are using all available audits, and governance processes to full effect. Regulation 17(1)
- The provider must ensure that there is an adequate number of specialist learning disability nurses in the service and that these nurses are always present in communal areas to offer support, role modelling good care and leadership to healthcare support workers and temporary staff. Regulation 18(1)
- The provider must ensure that they are checking support staff's competency and understanding following completion of their online learning disability training. Regulation 18(2)

Action the provider **SHOULD** take to improve:

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

- The provider should ensure that their admissions policy shows what measures are in place if a newly admitted people was then found to be too acute for the service to manage safely. Due to its design and layout the hospital environment was not suitable for acutely unwell people.
- The provider should ensure that all registered nurses are aware of and using the medicines as needed (PRN) guidelines.
- The provider should ensure that staff only use calibrated glucose monitors in the hospital.
- The provider should always ensure that people who are using the service can access all areas of the hospital and immediate environment safely and as independently as possible.
- The provider should ensure that the temperature in the hospital remains at a comfortable level.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement

Wards for people with learning disabilities or autism

Safe	Requires Improvement 
Effective	Requires Improvement 
Caring	Requires Improvement 
Responsive	Requires Improvement 
Well-led	Requires Improvement 

Is the service safe?

Requires Improvement 

Safe and clean care environments

Staff did not always provide people's care and support in a safe, clean, and well-maintained environment.

Cygnnet Views was originally a large house and was located on a hill in a busy tourist village location in Derbyshire. It had narrow corridors, stairs, and a small lift, to 8 of the 10 bedrooms on the upper floor. There were no seclusion or de-escalation rooms and limited other indoor space. The hospital environment was not suitable for people who were acutely unwell or with a history of ligation. This was acknowledged by the provider in their admission and access criteria and by the host Integrated Care Board. However, the hospital was caring for people who had become acutely unwell shortly after admission. This impacted on the safety and wellbeing of people who were using the hospital.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified.

The ligature audit completed in December 2022 correctly showed all ligature points that staff could not remove, the management of these risks was to be individually and locally managed.

This meant that the environment was only safe for people who did not have any history of ligating with fixed ligatures and whose mental state was settled and stable enough to allow access to all areas independently. In practice some people did not always meet these criteria and so staff had escort them around the hospital. This is not a practice we would expect to see in a rehabilitation placement and was not conducive to supporting people to develop confidence, self-management, and self-regulation in preparation for moving to community settings.

While closed circuit television was installed throughout the hospital it was organisational policy that it was not routinely checked in live time, only when staff wanted to review specific incidents. If staff are not checking closed circuit television routinely from a nursing or managers office, then the manager and nurse leaders cannot see what is happening in the various areas of the hospital and address anything untoward at once.

Wards for people with learning disabilities or autism

Staff reduced the risks of blind spots by use of convex mirrors, and their presence to see people in all parts of the hospital. There were enough staff to do this, and all staff were aware of people's observation levels.

Maintenance, cleanliness, and infection control

Although the service had recently had a refurbishment, it was not clean or well maintained in all areas. Cleaning records were not always up to date.

The closed culture survey completed by 10 respondents in February 2023, showed that 9 out of 10 respondents agreed the environment including communal areas, bedrooms, outside and inside spaces were clean and well maintained.

However, on the day of inspection, we found the splashback and sink in the therapy kitchen was not clean. This meant that there was risk of infection to people using the service. In response to our feedback and within one week of inspection, the provider sent an action plan to address the issue. They showed that the splashback would be re-covered, and a full redecoration and painting of the kitchen area was completed by 14 March 2023. The manager added cleaning of the therapy kitchen to the main hospital cleaning schedule rather than just therapy staff and people who used the kitchen. The manager made cleaning records more robust by requiring a second signature as part of routine audit. The manager rolled out national cleaning standards across the hospital by 20 March 2023. A host commissioner confirmed these actions during a visit to the hospital on 31 March 2023.

We found one bedroom was unclean and littered with toilet paper and empty toilet rolls. The staff member accompanying told us that this was what the person using the room does occasionally. That if they do not clean up and clear the bedroom themselves the housekeeper did it later in the day as part of her cleaning round. The team member returned later that day and found the bedroom was clean.

On the day of inspection, we found the hospital was hot. Staff could not control the heating in all people areas. This meant that people using the service could become too hot or too cold and this could affect their mood and wellbeing. Staff reported the issue reported to the facilities department. We reviewed the maintenance plan and although the maintenance team had assessed this situation there were no clear plans or completion dates for rectifying the issue.

Clinic room and equipment

Staff had not checked all the clinic room equipment. We found that staff had not ensured that all glucose monitors were calibrated. This meant staff could not be sure that the glucose readings for people were accurate which could lead to illness. However, one week post inspection, and in response to our feedback, the provider sent an action plan to address this issue. The plan stated that the head of care had removed all people's own glucose monitors from the clinic, and these will be stored securely until discharge. The service will support people who are monitoring their own glucose levels to use glucose monitors provided by, and maintained by, Cygnet Views.

Staff did not always clean the clinic thoroughly. The clinic room trolley, used for dispensing and preparing medicines, was not clean. The inside of a cupboard was not clean, and the accompanying nurse was not sure whose responsibility it was for cleaning these areas. This meant that there was risk of infection to people using the service. In response to our feedback the provider sent the following action plan to address the issue within two weeks of inspection completion. The plan identified that the head of care would undertake a thorough review of clinic and ensure that all areas are cleaned and organised. Regular cleaning of the clinic as per policy was to be re-instated and audited by head of care. This action started on 20 March 2023 and a visit by the Integrated Care Board on 31 March 2023 confirmed this was now routine practice.

Wards for people with learning disabilities or autism

Infection control

Staff did not always follow handwashing procedures. There was no protocol for managing people's laundry. However, staff did follow food hygiene and safety protocols and 84% of staff had completed food hygiene and safety training.

Staff did not always follow infection control policy, including handwashing. A copy of the hand hygiene audit tool for 25 February 2023 showed that there was 89% achievement. An action from the audit was that all staff needed to update themselves with the infection control policy. Training data for 15 March 2023 showed that 98% of staff had completed infection control training and 79% had completed handwashing training as per the hand washing audit. However, while we were inspecting the clinic room, we saw two nurses who were handling medicines did not wash their hands before or after the processes. This meant there was potential for cross contamination of infection leading to illness.

While inspecting the laundry we noticed that people's laundry was not easily identifiable. We could not tell whether laundry was dirty or clean, or who the laundry belonged to. This meant there was potential for cross contamination of infection leading to illness and people could become annoyed if their laundry was lost or given to the wrong person. We did not see any protocol for managing people's laundry.

Safe staffing

Nursing staff

While the service had enough staff to keep people safe, not all support staff showed that they could apply all the training they received.

The service had enough nursing and support staff to keep people safe. Managers accurately calculated and reviewed the number and grade of nurses, and health care assistants for each shift. They used a staffing 'ladder' to calculate how many staff were needed for the number of people on the ward. The service therefore knew how many staff were needed on each shift to keep people safe.

Total staffing establishment was, 5 whole time equivalent (wte) registered nurses, including a head of care, 1 wte nurse associate, 2 wte team leaders (senior healthcare support workers), 12 wte healthcare support workers, 3 wte provider pool bank healthcare support workers long term, and a full range of multidisciplinary team members.

Staffing establishment was 2 wte registered nurses and 5 wte healthcare support workers during the day and 1 wte registered nurse and 4 wte healthcare support workers during the night. However, the manager increased these numbers if people's needs required this, and commissioners paid for enhanced packages of care for people when needed. The hospital manager or head of care supported night-time shifts via an on-call duty rota, and a regional on call hospital manager for all weekend.

The service had 1 wte registered nurse and 3 wte healthcare support worker vacancies.

Staff turnover was high, at 31% for the previous 12 months.

Staff sickness was average for this type of service, at 6%.

Wards for people with learning disabilities or autism

We reviewed bank and agency staff usage between January and March 2023. During this period, bank staff were used on 12% of day shifts and 15% of night shifts. Agency staff were used on 6% of day shifts and 19% of night shifts. There were no vacant shifts or all-male shifts during this period. The manager was able to swap staff with a sister hospital not too far away to ensure the correct gender mix.

Records showed that all bank and agency staff had a full induction and understood the service before starting their shift. We reviewed 4 agency staff induction checklists and all 4 showed the induction as completed. However, 2 of the 3 agency healthcare support workers staff we spoke with said they had not received a full induction to the service. We could not verify these statements. The hospital used the organisation's own pool of bank staff, this was co-ordinated and supervised by the regional bank pool co-ordinator.

Staff shared key information about people when handing over their care to others, staff recorded this information and kept it in the nursing office. However not all support staff we spoke with showed they understood or were using this information, despite having been present at the shift handover.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go there quickly in an emergency.

The service had enough daytime and night-time medical cover. A doctor was available to go to the ward quickly in an emergency. The hospital had a part time responsible clinician supported by a full-time specialist doctor. Staff had access to the on-call doctor rota and urgent response in the evenings and weekends.

Mandatory training

Staff had completed and kept up to date with their mandatory training.

Permanent and bank staff had completed and kept up to date with their mandatory training, provided by Cygnet Healthcare. However, we noticed that most of the training that supported people skills and therapeutic interaction was e-learning and we could not determine how effectively staff were understanding and using this training in their practice.

Data on 15 March 2023 showed overall mandatory training compliance was 93%. Face to face training included, Induction training 100%; Basic life support and ligature resuscitation 97%; Intermediate life support (registered nurses) 100%; Safety Intervention Advanced Induction 100%; and Safety intervention advanced refresher 88%. E-learning mandatory training included Safeguarding Individuals at Risk 82%; Infection control 98%; Observation and engagement 100%; Positive Behavioural Support 100%; Promoting human rights 97%; and Relational security 100%.

Agency staff received their mandatory training through their respective agencies. All agency workers had to submit a personal profile to the hospital. This document included their name and contact details, photograph and brief pen portrait, the mandatory training they had completed, and date completed, along with their skills and experience of working with different people groups. These documents were signed and dated by their respective agencies, and hospital administration staff asked to see copies of original training documents to verify the record.

Assessing and managing risk to peoples and staff

Assessment of people risk

Wards for people with learning disabilities or autism

While staff tried to ensure that people were involved in managing their own risks whenever possible, this was not always successful. Staff were not always aware of the impact one person's expression of distress had on other people. Support staff were not always following people's risk management plans. Risk management plans were often focussed on managing the event when it occurred rather than pre-emptive risk management planning.

We reviewed 4 out of 7 risk management plans for people in the service.

Staff completed risk assessments for all people in the service using the Short – Term Assessment of Risk and Treatability (START) tool. All people had a positive behavioural support plan that matched the risk assessment and the person's goals and preferences. These documents were available in easy read format so that people could understand and manage their own risks where possible. However, 3 healthcare support workers we spoke with were not following these plans and 2 out of the 3 said they did not know about these plans, even though they were easily accessible in the nursing office and in each person's bedrooms.

Management of people risk

Most of the time staff managed people's risk well. However, the service was trying to work with a person who was acutely unwell, and this was having an impact on other people in the service and staff. Some staff told us they were not always aware of people's risk. One risk management plan we looked at in detail focussed on managing the event as safely as possible for the individual when it occurred rather than pre-emptive risk management planning.

The service was trying to work with a person who was acutely unwell. This was having significant impact on staff and people in the service. Due to the hospital environment and model of care, the service was not able to work effectively with people who were acutely unwell or who presented high risk to others. The environment at Cygnet Views was homely. The corridors and stairs were narrow to carry out the restraints safely and without impact on other people. There was no seclusion area or private quiet space for personal time out. Some staff lacked the skills and confidence to work with the acutely unwell person pro-actively rather than reactively. The impact of this was that some key staff often had to abandon work with other people or report writing because of the person's high level of need. Two staff members told us they could not do any work with people in the communal areas due to the upset this sometimes triggered for the other person. Two other staff told us they felt as though they were constantly on guard and firefighting all the time, leading to disillusionment with a job they usually enjoyed.

Two people using the service told us that the acutely unwell person targeted them by kicking and spitting at them and while staff stepped in to dissuade her from doing this, they did not prevent the attacks. One person told us this made them feel unsafe and the other said she was afraid to engage in any activity with staff or other people because she knew this might upset the other person and trigger an attack on her. We saw how when distressed the person would prevent access to other areas of the hospital, and while dealing with the incident staff stopped other people entering the area for their safety. One person told us this restricted their free movement about the hospital when normally there was no restriction on their movements. We heard how visitors to the hospital were sometimes prevented from using communal areas because of the upset this might cause the unwell person. We heard how another person's family visit to the hospital (the person did not have section 17 leave to go outside the hospital environment) had to be cancelled because the other person was having an unsettled day.

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We reviewed 4 of the 7 paper-based risk and positive behavioural support plans. While risk management plans were comprehensive and personalised, 2 of the 3 agency staff we spoke with on the day of our inspection told us they did not know about the plans and the third staff member told us he had heard of them but did not know where they were. All 3 staff told us they thought their main responsibility was to observe people in the service and step in if anyone became distressed, abusive to another or disruptive.

One positive behavioural support plan and associated risk management plan we reviewed did not give detailed actions staff should take to predict and prevent specific risk behaviours, such as how they should prevent a person from targeting other people and staff. We considered that given the persons diagnoses of autism and personality disorder there could be other more appropriate person-centred care ways of managing this situation.

While we saw how the multidisciplinary team discussed risks and updated risk plans, we were not assured that the multidisciplinary team shared these plans with the staff who were supporting people. Healthcare support workers we spoke with told us they did not know about changes to people's risk. They said that multidisciplinary staff did not involve them in these decisions. We reviewed nursing handover notes and observed a nursing handover meeting, we did not see evidence of discussions about changes to peoples' risk or risk management plans.

Use of restrictive interventions

Staff usually only used restrictive practices as a last resort, for the shortest time and in situations where people were a risk to themselves or others. However, since reopening to new admissions in June 2022, the service has had 3 new admissions who became acutely unwell shortly after arriving at Cygnet Views. This has resulted in a gradual increase in use of restrictive interventions and rapid tranquilisation.

Mandatory training compliance for physical intervention was 88%.

Data from 01 September 2022 to 29 November 2022 showed there was a total 149 incidents. Of these incidents 122 involved 2 people who were using the service, 68 of these incidents had resulted in a restraint procedure and 19 of the restraint procedures had resulted in rapid tranquilisation.

In comparison, data from 01 December 2022 to 28 February 2023 showed there had been a total of 283 incidents, primarily involving 3 people who are using the service. Of these incidents, 131 resulted in a restraint procedure and 56 of the restraint procedures had resulted in rapid tranquilisation.

Further analysis of the data for December 2022 to February 2023 showed that most of the restraint procedures were low level, and that staff were trying other strategies before using restraint as a last resort. Staff had offered peoples oral medication prior to administration of any rapid tranquilisation via intramuscular medication.

The manager told us that following review of the recent data, and in response to the increase levels of distress and use of restraint, the team requested support from the organisation's safety intervention team (SIT). She added that the SIT attended site on 3 occasions to review incidents with staff and provided consultancy and support to the staff team. In addition to this the head of care and the psychologist have provided training, debrief and formulation for the team to consider one person's particular distress and potential ways of working together to support that person.

Safeguarding

Wards for people with learning disabilities or autism

People were safe from abuse. Staff understood how to protect people from abuse and the service worked well with other agencies to do so.

Staff received training on how to recognise and report abuse, appropriate for their role. Training records showed 82% of staff had completed Safeguarding individuals at risk training. The managers recognised this training as the equivalent of safeguarding adults' level 3 and safeguarding children level 2.

Staff kept up to date with their safeguarding training. There was a system to alert managers and staff when they needed to update or refresh their training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff said they felt confident to raise issues with the senior management team. They knew the procedures for making referrals to the local authority. Managers knew which safeguarding concerns to report direct to the regulator. Managers were aware of risks to children who were part of a people's family or circle of friends and said they would act if concerns were raised about their safety as well.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – both paper-based and electronic.

People's notes were comprehensive, and all staff could access them easily. Staff used both electronic and paper records and both were complete. They included up-to-date risk assessments, positive behavioural support plans, this is me pen portraits, personal evacuation plans, COVID-19 information, and information on people's physical health.

All authorised staff, including bank and agency, could access people notes. They were available in the people's handbook in the nursing office and people's bedrooms, and as grab sheets in the nursing office. However, 3 healthcare support workers we spoke with said they did not use them and 2 of these staff did not know about them.

Staff stored records securely. Staff kept paper notes locked in the nurses' office and electronic notes were on a secure system.

Medicines management

Staff were not always following as and when needed (PRN) protocol. It was not obvious how 2 people, one on high dose anti psychotics and another on frequent intramuscular medication were being monitored. However, within two weeks of the inspection concluding and in response to our high-level feedback, the manager sent confirmation and evidence to CQC of how both issues had been addressed.

Although data showed that 100% of registered nurses had completed medicines management training, they did not ensure that the medicines as needed (PRN) protocol was being followed. The doctor formulated the PRN protocol, which was advisory rather than mandatory, and set out what order a people's PRN medication should be offered. One registered nurse did not know that there was a PRN protocol. If staff are not following PRN protocol as decided by the doctor, then people might be receiving the wrong medications at the wrong times. However, the manager confirmed

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that the PRN protocol had only been reintroduced the week earlier, having been suspended for a couple of months prior to that, and so it was possible that some nurses might have been aware of reintroduction. We received evidence within one week of the inspection from the manager explaining what steps she had put in place to ensure that all nurses knew about and were using the PRN protocols.

Staff followed systems and processes when safely prescribing, recording, and storing medicines, they followed current national practice to check people had the correct medicines. Staff followed national practice to check people had the correct medicines when admitted. Staff checked the temperatures of the clinic room and medicines fridge so that people's medicines were stored safely.

Staff completed most medicine audits and pharmacists cross checked these for accuracy. Medicines records were complete and held details on dose, when people received them, and a second staff member double checked all controlled drugs.

The doctor followed good practice guidelines to ensure that people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff used the principles of stopping over-medication of people with a learning disability and autistic people (STOMP) to only administer medicine that helped people's recovery or as part of ongoing treatment. STOMP was clearly discussed in each person's care plan. Doctors reviewed each person's medicines and gave clear direction to staff about the medicines each person was prescribed.

Staff reviewed each person's medicines regularly and provided advice to people and their carers about their medicines, a family member we spoke with confirmed this. We saw a staff member talking with a person about their medicines supporting them to decide if they wanted to take it or not. Staff provided information about medicines in accessible formats on request.

Staff reviewed the effects of each person's medicines on their physical health according to National Institute for Health and Care Excellence (NICE) guidance.

Track record on safety

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave people honest information and suitable support.

Staff knew what incidents to report and how to report them. They followed clear guidelines and could describe the process for reporting incidents. Staff reported serious incidents clearly and in line with trust policy. The type and number of incidents received by CQC matched those in the incident records we reviewed.

Staff understood the duty of candour. They were open and transparent and gave people using the service and their families a full explanation when things went wrong. We saw evidence of this in investigation reports and on complaint trackers.

Managers debriefed and supported staff after any serious incident. Staff had support from a psychologist. Managers encouraged staff to take part in reflective practice following any incident. The manager had started additional support for staff following an increase in the number of incidents recorded due to increase in distress at the hospital.

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Managers investigated incidents thoroughly. People using the service and their families were involved in these investigations. Staff followed a clear process for reporting and investigating incidents. There were incident review meetings to examine all actions following an incident. Managers held clinical governance meetings and quality improvement meetings every month, during which they discussed recent incidents. Our review of minutes of the meetings showed how people and families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers held team meetings where they shared lessons learned with staff. They recorded this in meeting minutes.

Staff met to discuss the feedback and look at improvements to people care. They discussed the lessons learned at staff meetings and handovers. The psychologist found themes and used these to encourage reflective practice sessions aimed at improving care.

Is the service effective?

Requires Improvement 

Assessment of needs and planning of care

Assessment of people's needs started at admission. Care and support plans were holistic and reflected people's needs and aspirations. People, those important to them and staff developed individualised care and support plans. Staff completed functional assessments for people who needed them. They took the time to understand people's behaviours.

We reviewed 4 out of 7 sets of care records for people who were using the service, and case tracked 1 other set of notes.

Staff completed a comprehensive mental health assessment of each person either on admission or soon after. People's records showed that the multidisciplinary team completed an assessment of all their needs and plans showed how staff were to support the person to meet these. Staff assessed people's physical health soon after admission and regularly reviewed this during their stay. Staff recorded all the needs from the assessments in the person's care record stored in the nursing office and on the electronic data base. Staff made sure that all people's care needs were available as an easy read grab sheet kept in the nursing office.

Staff registered people with a local GP. Staff assessed people's physical health daily and made referrals to their GP or specialists when needed. Staff developed a comprehensive care plan for each person that met their mental and physical health needs. Care plans were personalised, holistic and strengths based.

People's records showed that they were involved in all parts of their plan and contributed their views. Staff regularly reviewed and updated care plans and positive behaviour support plans when people's needs changed. People were involved in reviewing and updating their plans. Staff were aware of people's care plans and positive behaviour support plans and what support each person needed. Positive behaviour support plans were present and supported by a comprehensive assessment. Staff were aware of these for individuals and followed them.

Physical healthcare

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Although staff carried out and recorded routine physical health checks on all people using the service, it was not always obvious how staff monitored the physical health of people who refused these checks.

We reviewed all 7 medical records. It was not obvious what alternative methods staff used to routinely monitor the physical health of 2 people. One person was on high dose anti psychotics and another on frequent intramuscular medication. While both people were refusing the physical health checks offered by staff, there was no evidence that staff did any other observational monitoring instead. If the person's physical health is not being checked in accordance with policy and guidance, then that person could develop serious illness or be exposed to unacceptable harm.

However, within two weeks of the onsite part of the inspection concluding, and in response to the high-level feedback letter the provider sent the following action plan to address this issue. Care plans to be updated to reflect contingency strategies for when people decline to have their physical observations checked, for example, visual observation of alertness, any side effects observed, respirations, pallor, mobility issues and completion of side effect monitoring forms (Ashtons side effects monitoring forms) to be reviewed in people review and ward round meetings. This action was completed by 20 March 2023. We saw copies of the care plan and side effects monitoring form to reflect this.

Best practice in treatment and care

Staff made every attempt to provide care and treatment for people in the service, to ensure the service always delivered care in line with best practice and national guidance. However, the setting and design of the hospital and the level of risk management needed to manage some of the more acutely unwell people meant that the service did not always fully reflect the CQC guidance 'Right support, Right Care, Right Culture'. Registered nurses were not always present in the communal areas to offer healthcare support workers guidance and role modelling of best care and practice.

Although there were opportunities for people to be meaningfully occupied, on occasion some staff did not know how, or did not feel confident to engage people in meaningful activity particularly if the person had declined the first offer of an activity. At various times of day during our inspection we saw up to 5 people at a time sat or laid around in the lounge while 3 or 4 staff members stood around the edge of the room watching them. There was minimal verbal and physical interaction between people and the staff members. Two people we spoke with said they were bored and there was nothing to do that day, while two of the staff members told us they believed therapy staff did the activities and it was their role to watch people and intervene if they became distressed.

However, we reviewed CCTV footage recorded in the communal area between 20 February and 01 March 2023 and saw that staff had appropriately supported and interacted with people in 14 out of 15 clips we reviewed. We saw staff and people talking to each other, staff supporting people with activities of daily living, staff and people playing interactive games together and staff encouraging people to engage in social group conversation. The closed culture survey completed by 10 staff in February 2023 also showed that that everyone answered yes to the question "do you see care staff and professionals interacting with service users routinely throughout the day?". Therefore, we judged what we had observed during the inspection to be the exception rather than the rule.

The hospital had limited inside space. The hospital was a large, converted house. The main communal area was an open plan lounge and dining room. The corridors and staircase were narrow and winding and the accessible through floor lift could only accommodate three people comfortably. This meant that when a person required physical

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intervention to help manage their distress, and to support their dignity and privacy, parts of the hospital needed to be cordoned off. This restricted people's free access around the environment and sometimes resulted in the cancellation of planned activities, visits, and therapy time such as open advocacy sessions. These periods of time could be for up to an hour or more.

People were not always able to access the community unaided, even though their section 17 leave allowed for this. Cygnet Views was located at the top of a steep hill, and access from the pavement into the hospital was via a cobbled driveway. While the town centre where the shops and cafes were located was flat with tarmac roads and pavements it was some distance from the hospital. The rest of the village had several steep narrow roads some of which were cobbled. This made it difficult for people with limited mobility to walk to the town centre or around the village. Although the hospital was located in a quiet residential area of the village, Matlock was a popular tourist and hiking area. It was often busy with tourists and cars that could be overstimulating for some people with sensory needs. This limited some people's access to outside activities, which had to be planned around these factors. It was essential that people learned to use the community environment independently, to develop their confidence with independent community living skills.

However, within the hospital, people's sensory needs were considered. People's records included assessments for weighted blankets and people said they had these, which helped to meet their sensory needs. A room had been refurbished which included a range of sensory equipment which people said they found relaxing.

People took part in a range of activities including education, with Maths and English classes held at the hospital. People had opportunities to do jobs in the hospital for which they received payment and they said this helped to promote their wellbeing. They used the hospital vehicle to ensure physical health and group activities could still go ahead along with home visits and any other activities requiring transport. People had bus passes so they could use public transport when it was running. People did activities in the hospital which they enjoyed such as arts, crafts, and jigsaws, staff had framed some of these this helped to promote people's self-esteem and celebrate their achievements.

The psychology team supported people at the service and staff. They played an active role in the multidisciplinary team, completing analysis of incidents and risk assessment. There was a qualified psychologist who worked at the service 3 days a week and an assistant psychologist who worked at the service five days a week. The qualified psychologist had daily oversight of Cygnet Views as they attended the daily morning meetings. The psychologist said they had enough time to spend working with individuals. They were able to provide examples of the work they had completed to support people. For example, they had recently started a 'Relationships Group' that was adapted to meet the needs of people to help them to understand how to form relationships, and about health and sex education. People told us they did mindfulness and relaxation exercises to promote their wellbeing.

In addition to psychology there was a speech and language therapist, an Occupational therapist, education facilitator, and therapy co-ordinator. These all worked with the psychologists and doctors as part of the multi-disciplinary team.

All permanent staff and most temporary staff understood people's positive behavioural support plans and provided the identified care and support. All staff had access to these, and they were up to date. Staff developed a positive behaviour support 'grab sheet' for each person. These were developed so that each person had which was one page so that staff could clearly see how to support the person.

People had hospital passports. When a person with a learning disability goes into hospital the hospital passport holds all their essential information to help staff at the hospital to know how to support them. If a person from Cygnet Views needed to attend hospital, staff from the service supported them during their stay.

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Staff made sure people had access to physical health care, including specialists as needed. People had access to well woman checks and tests to ensure they were healthy. Staff supported people to have cervical smear tests and asked which staff the person wanted to support them to attend these. People had regular eye tests and dental check-ups.

Staff completed training in dysphagia and people's records showed that staff assessed their risk of choking and if foods needed to be adapted to reduce these risks. Staff checked and recorded people's weights. People's records included a Malnutrition Universal Screening Tool (MUST) assessment to identify if they were at risk of malnutrition or obesity. Where risks were identified a care plan was in place as to how staff were to support the person. Staff made records of fluids and food consumed by people to make sure they ate and drank enough.

Staff referred people to dieticians when needed. Staff used suitable recognised rating scales to assess and record the severity of people's conditions and care and treatment outcomes. For example, the hospital used the Learning Disability Model of Human Occupancy Screening Tool (LDMOHOST) and the Disability Distress Assessment Tool (DISDAT).

Staff used technology to support people to stay connected with their families when they were unable to see them face to-face. Where risk assessment indicated people had their own phones to stay connected with their friends and relatives.

Staff took part in clinical audits and there was a programme of improvement taking place. There were several clinical audits and managers used results from audits to make improvements and shared learning with the staff team. For example, staff had improved the quality of the records they kept about people using the service which showed the care they had provided. The Cygnet Quality Assurance Manager had visited the hospital weekly following our earlier inspection and supported staff to make improvements.

Skilled staff to deliver Care

Not all staff demonstrated that they were skilled, competent, experienced, or confident when working with this client group. However, we judged this to be due to lack of managerial guidance, role modelling and capability monitoring, rather than availability or compliance with training or supervision. We noted that most of the training supporting people skills and therapeutic interaction with people was e-learning and we could not determine how effectively staff were completing this training and using it in their practice. If staff do not have relevant skills, experience, or knowledge of the people group then they are not going to be able to identify and meet their needs effectively.

All the registered nurses were mental health or general nurses. The service had no learning disability specialist nurses; however, the multidisciplinary team members did have learning disability specialism.

Staff told us they gained learning disability knowledge through experience of working at the hospital and with the people. We saw most of the training that supported people skills and therapeutic interaction with people was e-learning. As there was no obvious capability assessment of staff's skills, we could not determine how effectively staff were completing this training and using it in their practice. Staff told us if they asked questions about specific people they were looking after their questions would be answered by the multidisciplinary team and this was how they gained their knowledge.

We spoke with 3 agency support workers. None of them realised that part of their role was to support people with therapy interventions. Two of these staff did not understand what therapeutic intervention was. None of them had

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looked at or knew what was in peoples care plans and PBS plans, even though these paper documents were readily available in the nursing office. One of the support workers did not understand our questions. Although we considered this could be due to their anxiety about being interviewed by CQC inspectors, we wondered how they would be able to communicate effectively with the peoples.

None of the support staff we spoke with knew how to motivate peoples. We saw one staff member offer a person the opportunity to do some colouring, this was refused by the person, but the support worker did not explore with the person why they did not want to do this or if there was something they would rather do. We looked at the persons positive behavioural support plan and it clearly stated what interested them and how she liked to be encouraged.

However, all permanent, bank and agency staff had completed an induction and the induction was comprehensive. Supervision records were comprehensive. Compliance with supervision was 95%, and appraisal was 94% for permanent and bank staff. Agency staff did not get supervision from staff at Cygnet Views.

Specialist training for permanent and bank staff included Learning disability awareness (e-learning) 96%; and Personality disorder awareness (e-learning) 100%; Observation and engagement (e-learning) 100%; Positive Behavioural Support (e-learning) 100%; promoting human rights (e-learning) 100%; and Relational security (e-learning) was 100%. Oliver McGowan training on learning disability and autism (e-learning) was mandatory and compliance was 96%.

We gave this feedback to the manager at the end of our inspection. Within 2 weeks the provider sent the following action plan to address these issues: Staff will be required to maintain their skills by completion of relevant Achieve modules focussing on supporting people with Learning disability and Autistic spectrum disorder. Temporary staff induction will include guided familiarisation with the content of Positive Behavioural Support Plans, and care plans. The manager will liaise with human resources about preferential recruitment of learning disability nurses. The new head of care had already identified the need for competency checks and more visible nurse leadership in the people areas which will show any shortfalls in staff's ability to understand and apply the training they have undertaken.

While we accept that these plans would address the issues identified, it did not change our judgement of the service at this time as the plans had not had time to be fully implemented and embedded into practice.

Multidisciplinary and interagency teamwork

A team of staff from a range of disciplines worked together to support people and ensure care was delivered and outcomes achieved in line with care and discharge plans.

The service had access to a full range of specialists to meet people's needs. This included doctors, psychologists, speech and language therapists, occupational therapists, and nursing staff. The multidisciplinary team linked in with that at another local Cygnet hospital to share knowledge and experience and case discussion.

There were regular multidisciplinary meetings to discuss people's needs and improve their care. Staff made sure they shared clear information about people using the service and any changes in their care in daily 'morning meetings' through reading care plans and in multidisciplinary review meetings.

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Staff had effective working relationships with other teams in the organisation and with external teams and organisations. Since our earlier inspection there had been regular meetings led by the local Clinical Commissioning Group (CCG) now known as the Integrated Care Board and attended by representatives of the provider, people's community teams, safeguarding teams and CQC. The provider had contributed to these meetings and provided assurance of improvements made to the service.

People's community teams were invited to their review meetings and took part in these. The hospital had good working relationships with the local safeguarding teams.

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

Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983, and the Mental Capacity Act 2005.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. 95% of staff had completed this training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. People had easy access to information in accessible formats about independent mental health advocacy and people who lacked capacity were automatically referred to the service.

Staff explained to each person their rights under the Mental Health Act in a way that they could understand. The speech and language therapist had developed accessible information and staff used these to explain to people their rights.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Staff discussed this in people's review meetings and staff completed risk assessments before people went on leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of people's detention papers and associated records correctly and staff could access them when needed.

Staff gave people who were informal people information about their rights in a format accessible to them that explained they could leave the ward freely and they and their relatives understood this.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Managers completed audits as part of their audit schedule.

Good practice in applying the Mental Capacity Act

Staff supported people to make decisions about their care. Staff understood the Mental Capacity Act 2005, including Deprivation of Liberty Safeguards. For people that the service assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any best interest decisions.

Staff received and kept up to date with training on the Mental Capacity Act and 96% of staff had completed training.

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Staff we spoke with had a good understanding of at least the five principles. There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff gave people all support to make specific decisions for themselves before deciding a person did not have the capacity to do so. Staff used information developed by the speech and language therapist to maximise the opportunity for individuals to make decisions. Staff assessed and recorded capacity to consent clearly each time a person needed to make an important decision. When staff assessed people as not having capacity, they made decisions in the best interest of peoples. They considered the person and their relatives where appropriate wishes, feelings, culture, and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications. The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. Managers completed audits as part of their audit schedule.

Is the service caring?

Requires Improvement 

Kindness, privacy, dignity, respect, compassion, and support

While we saw how staff were discreet and respectful when caring for people. Some staff did not always meet individual care needs or treated people in a way that encouraged peoples to achieve their potential.

On the day of our inspection 3 out of 5 of the support workers we spoke with did not appear to be interested in the people or dedicated to providing high quality therapeutic rehabilitative care. When asked, they could not describe in any meaningful way how they applied therapeutic observation or how to engage people in active participation. Two of the staff told us they had not looked at people's care plans or positive behavioural support plans and did not know what their preferences, likes and dislikes were. If a person's social, psychological, and functional skills are not encouraged or met as per the persons care plan, the person can lose these skills, or not develop them in the first place. This can result in the people needing to be more dependent on others than they would be if all their needs were being met.

One person told us she had not had any breakfast and she was hungry; it was 11.00am. Staff had not realised this or asked her if she had breakfast even though she was still wearing her dressing gown and appeared to have just woken up. The manager who was accompanying us had to ask a staff member to sort out some breakfast for her. The person told us later she could not remember what staff had told her about the hospital when she arrived, she did not know how the hospital worked or what was expected of her. She did not know what to do at mealtimes if she was not able to be there when staff served the meal. Staff had not thought to check out her understanding of the information given to her on arrival.

During our inspection we carried out two observations of the open plan communal lounge and dining room. We saw up to 3 staff and 4 people who use the service. None of the staff at any time had any meaningful interaction with people. Staff told us they believed their role was to watch people and intervene if anyone became distressed or wanted a drink or snack.

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However, this proved to be the exception rather than the norm. Post inspection we reviewed 20x 30-minute pieces of CCTV footage, sampled at random by ourselves from various dates and times between January 2023 and March 2023. All the footage was showing the communal lounge dining room areas. Only 1 sample showed staff not interacting with peoples for fifteen minutes or more. In all other samples we saw staff socially interacting with peoples appropriately.

Review of the closed culture survey completed by 10 respondents in February 2023 showed that in response to the question “do you feel your colleagues behave appropriately towards service users?” 4 people agreed strongly, 3 agreed, 2 people neither agreed nor disagreed and 1 person disagreed. In response to the question “do your colleagues understand the impact their behaviour may have on colleagues and or service user – either directly or indirectly?” 7 people either agreed or agreed strongly, 1 person neither agreed nor disagreed and 2 people disagreed.

Involvement in care

While people, and those important to them, took part in making decisions and planning of their care. People did not always know who the staff were, and their access to open advocacy was not always possible. This sometimes made them feel uncomfortable around staff and prevented them from exercising their autonomy.

We reviewed 4 people’s care plans. Care plans included easy read information to enable the person to be involved in their care. Care plans focused on people’s strengths, and they worked with staff to focus on their goals and hopes and dreams for what they wanted their life to be.

People were able to feedback on their care and support. There were regular meetings with the people who used the service. Minutes of the Community meetings and People’s council meetings from January to March 2023 showed that staff encouraged people to share their thoughts and ideas. These discussions included suggestions for more activities off the unit such as swimming and horse care. People discussed their frustration about how unsettled the unit had been and their need to get off the unit to relieve some of the stress this caused them.

The individual satisfaction survey dated February 2022 was completed by people who used the service and asked people to comment on 10 statements including, I am happy with my bedroom; I feel safe; Staff treat me with respect; I know how to make a complaint; Staff give me information to make my own decisions; and I am listened to. There were five people at the hospital at the time and all five responded to the survey. The survey returned 94% people satisfaction rate.

However, there was no staff photo board or information about staff that people could refer to. Staff did not wear easily identifiable name badges. If people do not know who is looking after them, they may not feel comfortable approaching staff for help or assistance when they need to. This can reduce the persons confidence to seek information and advice from staff that would enable them to make informed choices for themselves.

The advocate told us that she could not carry out her work as effectively as she would like. She often could not use the communal areas of the hospital to meet with people or hold group discussions. She explained this was because the sessions were often disrupted by another unsettled person and this sometimes made parts of the environment unsafe for her to work in. Access to advocacy in all its forms can support people to be autonomous and if this is not always available then a service cannot be sure that peoples’ voice was always being heard.

Involvement of families and carers

Staff usually supported people to maintain links with those that are important to them.

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One person, whose family lived some distance from the hospital, told us how the service had supported her family to visit her by paying for their travel and accommodation. Another person told us staff had supported a person to visit a relative, they had not been in contact with for several years. Staff knew how difficult this would be for the person and supported them through this.

Staff maintained contact and shared information with those involved in supporting people, as appropriate. Relatives said they were invited to reviews and were involved as much as they could be. However, one relative said they had not been able to attend their family member's last review meeting and had not received any notes from it. One person told us they did not want their family to be that involved in their care and staff respected this choice.

Is the service responsive?

Requires Improvement 

Access and discharge

People had discharge plans with clear timeframes in place to support them to return home or move to a community setting. Staff liaised well with services that provided aftercare, so people received the right care and support when they went home. However, the admission policy did not show what measures were in place if a newly admitted person was subsequently found to be too acutely unwell for the service to manage safely.

The provider's admission policy and protocol was regularly discussed in stakeholder engagement meetings prior to our inspection. In December 2022, the managers revised the admission policy and the service model of care. We reviewed the revised policy and saw the new protocols were in place and staff were using them. However, the policy did not show what measures the manager should take, or what the expectation was of the referring body, if newly admitted people should happen to deteriorate and become acutely unwell during the first few weeks of admission. Therefore, becoming unsafe for this service to continue with the admission. If there are no measures in place to either return the person to their original placement or transfer them quickly to a more suitable placement the deteriorating situation can affect other people using the service as well as the person themselves. The hospital can quickly become unsettled for other people and distressed person could be exposed to risk either to themselves or others, because the environment does not support their needs or staff do not have the skills and knowledge to work with them effectively.

Bed management

Although managers regularly reviewed people's length of stay to ensure they did not stay longer than they needed to some people's length of stay was sometimes longer than expected. The service admitted people from across the United Kingdom. This meant people were not always located close to their families or their own communities. Due to the complexity of some people's health needs bespoke placements could take longer to source than expected. Most people stayed at Cygnet Views for between six months and two years.

The manager told us that although the hospital could accommodate 10 people, due to the current complexity of people's needs, and the hospital environment and facilities, they would be unlikely to want to fill all these beds. We saw that one person occupied two rooms to meet her needs. After the inspection, the manager told us they had decided to voluntarily not admit any further people until they were able to transfer some of their more complex people to more appropriate placements.

Wards for people with learning disabilities or autism

Discharge and transfers of care

We saw that all people had discharge plans with clear timeframes in place to support them to return home or move to a community setting. Staff liaised well with services that provide aftercare, so people received the right care and support when they went home.

Managers and staff worked to make sure they did not discharge people before they were ready. The multidisciplinary team discussed people's discharge from the service and what needed to be in place to ensure this met the person's needs and was safe. People went on leave to their new placement before their discharge was confirmed to make sure it was appropriate to their needs and safe. When people went on leave there was always a bed available when they returned. Staff did not move or discharge people at night or early in the morning.

Managers monitored the number of people whose discharge from the hospital took longer than expected. There were two people whose discharge from the hospital took longer than expected. This was due to the lack of available community placements to meet their needs. Staff carefully planned people's discharge and worked with care managers and coordinators to make sure this went well.

Facilities that promote comfort, dignity, and privacy

Staff respected people's privacy and dignity. Each person had their own bedroom with an en-suite shower room. People could personalise their room and keep their personal belongings safe. The furnishings and décor were comfortable. People could access drinks and snacks at any time. However, the services location, design and layout did not always fully support people to be independent, quiet areas for privacy other than bedrooms were limited. People said the food could be better.

Each person had their own bedroom, which they could personalise. People said they liked their bedroom and could personalise it in the way they wanted to. People had been involved in the redecoration of communal areas of the hospital. People told us their views had been listened to and the service was less clinical and more homely.

People had a secure place to store personal possessions. People told us that they could store their possessions in a different room if they thought having their clothing for example in their bedroom could put them at risk of harming themselves.

People could make phone calls in private. There was a telephone for people to use although they said they did not use this as they used their own mobile phones.

Although staff had access to a range of rooms and equipment to support treatment and care, space for personal quiet time and individual work was limited. This meant that when people were experiencing distress or needed longer periods of 1 to 1 support the only private quiet space was their bedroom. Due to a lack of other space, the meeting room was often in use and not always available for visitors to use.

There was a separate building outside of the main hospital that accommodated a hair and beauty salon and medium sized meeting room. However, during the inspection we saw that staff were using the hair salon as a storeroom and extra working space for themselves.

Wards for people with learning disabilities or autism

Although the service had a well-kept outside garden space, people could not access this independently. Staff had to always support people in the garden to use this due to ligature risks. Some parts of the garden were not suitable for people whose mobility was limited. This meant that people could not access the outside area independently.

The hospital was in an uphill location and was not easily accessible. There was little parking (4 cars only) on the hospital forecourt. All other vehicles had to park on local roads nearby many of which were on steep gradients. Due to the steep inclines some staff and peoples did not like walking too far and when the pavements were icy, or snow covered it was not safe. To mitigate this fact the manager told us they would not admit a person with limited mobility to the Views as this would negatively affect on their quality of life there. The village was also a popular tourist destination. This meant it was extremely busy with visitors, and traffic meaning that the environment outside of the hospital was often too stimulating for some people with a learning disability and autism to enjoy.

People's engagement with the wider community

Staff supported peoples with activities outside the service, such as work, education, and family relationships.

The service gave people the opportunity to engage in paid work which supported staff to complete practical tasks. People could take part in Maths and English classes at the hospital and there were links with local colleges.

Staff helped people to stay in contact with families and carers. Families and carers visited the service and used technology to have virtual meetings with family. Staff encouraged people to develop and support relationships both in the service and the wider community. Staff encouraged friends and families to visit when they wanted to, and people were encouraged to hold these visits off the hospital site whenever possible.

The closed culture survey completed by 10 respondents in February 2023 and in answer to the question “do people working at the service encourage other professionals, relatives and carers and those important to the service user to regularly visit service users?” 9 out of 10 people said yes.

Meeting the needs of all people who use the service

Although the environment presented physical challenges for some people, as described above, the service did meet all other needs of people using the service, including those with needs related to protected characteristics. Staff helped people with advocacy, cultural and spiritual support. Staff always met people's communication needs. People had access to information about their rights under the Mental Health Act, care plans, risk plans and positive behavioural support plans in easy read pictorial and large print formats.

Staff supported people with communication needs. The speech and language therapist assessed people's communication needs and staff followed individual communication plans. They provided information in a variety of formats including pictures, easy read, symbols, and use of Makaton (sign language). This made sure people could access information on treatment, local service, their rights and how to complain. There was a 'Makaton sign of the week' which staff used and encouraged people to do so and improved their knowledge of Makaton.

The service provided a variety of food to meet the dietary and cultural needs of individuals. Most people we spoke with said they had the foods they wanted, and staff presented these in the way they wanted them to meet their dietary needs. However, two people told us the quality and choice of food had not been good for the last few months.

Wards for people with learning disabilities or autism

People had access to spiritual, religious, and cultural support. Staff had provided a range of materials for people to use to practice their religion if they wanted to. These were available in a room that was dedicated as the multi faith and sensory room. Staff asked people during their assessment what support they wanted to meet their spiritual needs. Staff had supported people to develop keeping well plans and one person told us staff had helped them to develop and advanced directive.

Listening to and learning from concerns and complaints

People, and those important to them, could raise concerns and complaints easily and staff supported them to do so. The service treated all concerns and complaints seriously investigated them and learned lessons from the results. They shared the learning with the whole team and the wider service.

People and their relatives knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in formats that were accessible to individuals. There was a notice board that told people using pictures and easy read information about how to suggest something, compliment the service or make a complaint, there was a box provided for people to do anonymously if needed.

Staff knew how to acknowledge complaints and people received feedback from managers after the investigation into their complaint. This was demonstrated on the complaints trackers we reviewed and in the minutes of community meetings. In the 12 months prior to inspection the service received 24 complaints, 19 of which were from people who used the service. Complaints were responded to at following community meetings and there was a 'You said, we did' board that showed action was taken when people provided feedback about the service. Managers shared feedback from complaints with staff through team meetings and individual e mail. The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Leadership

The new leaders, specifically the registered manager and head of care, had the skills, knowledge, and experience to perform their roles. They understood the services they managed and could describe the vision for the service. However, they had only been in post 5 weeks.

Since our earlier inspection in March 2022 there had been 2 changes of leadership and the service had reopened to new admissions in June 2022 after a period of not taking admissions due to the dynamics at the hospital at that time and needing to undertake quality improvement work at the service following the previous CQC inspection. The findings from this inspection showed that during this transitional period not all governance processes were maintained robustly. The admissions policy and procedures were not working as well as they should. Although managers had reviewed the admission policy, procedure, and model of care in November and December 2022, they had not had chance to become embedded into practice.

All the staff and people we spoke with said they had met the new managers and they were confident and friendly. Registered nurses were not always visible in the communal areas to offer leadership and role modelling of good people care. They were not always available to support junior staff and people using the service.

Wards for people with learning disabilities or autism

We reviewed 15x 20-minute clips of closed-circuit television footage of the communal areas. We did not identify registered nurses regularly in the communal areas or anyone giving direction and role modelling to the rest of the staff. Five staff and 2 people told us that nurses were not often in the communal areas though occasionally one or two might sit in the dining room to do their paperwork.

Not all staff, primarily healthcare support workers, were using and following the comprehensive care plans produced by the multidisciplinary team. No one was checking or addressing this issue. 3 out of 5 support staff we spoke with (all agency staff) told us they were not aware that they should have been looking at this documentation and were not aware that supporting peoples with their therapy plans was part of their role. Unless activities were facilitated by the multidisciplinary team or therapy co-ordinator, healthcare support staff, (primarily agency staff) did not feel confident supporting peoples with their rehabilitation.

If registered nurses are not visible in the communal areas most of the time, then there is no one to check quality of the work and interaction being undertaken with peoples by support staff. When registered nurses are working alongside support staff, particularly new staff and agency staff, they can ensure that staff are using care plans, positive behavioural support plans and risk plans correctly and know where to find them.

As part of our feedback, we highlighted this issue. Although the managers sent us an action plan of how they would address the issue within 2 weeks of our inspection, we were not assured this was adequate mitigation as the plans had not had chance to become embedded in practice.

Vision and strategy

Staff knew and understood the provider's vision and values and how to apply them in the work of their team.

All permanent and bank staff, and 1 of the 3-agency staff members we spoke with knew and understood the providers vision and values and how these related to their work. Staff received training around the organisations vision during their induction.

Culture

While the culture towards people using the service was good, some staff we spoke with said the culture towards themselves was not always good.

We spoke with 3 people using the service, 2 family members of people using the service, 14 staff and reviewed the findings of the closed culture survey completed in February 2023. We found that only 3 out of 14 staff felt the provider promoted equality and diversity, and 6 out of 14 staff we spoke with did not feel respected, supported, and valued. However, all staff acknowledged that initiatives such as having a new staff room, flexible work hours, opportunity to gain different skills and perspectives on care by doing some shifts at the Views sister site, managers providing drinks from a coffee shop on Fridays, and toiletries in the staff rest rooms, had helped to promote their wellbeing.

The closed culture survey completed by 10 respondents in February 2023 showed that in response to a question about staff feeling "...able to constructively and compassionately challenge each other when appropriate behaviour is not displayed between each other or towards those in their care?" 10 people said yes. While in response to the question "how comfortable and confident are you in raising concerns about your colleagues?" All 10 people said they were confident or confident.

Wards for people with learning disabilities or autism

We heard how Cygnet used a staff survey provided by an independent company for all staff to take part in anonymously.

All staff were aware of the role of the Freedom to Speak Up Guardian at Cygnet and knew how to contact them. While 5 staff told us they did not feel confident raising issues with managers direct, they did feel confident to raise their issues with the freedom to speak up guardian. The closed culture survey completed by 10 respondents in February 2023 showed that in response to the question “how comfortable and confident are you in raising a concern about service user care?” All 10 people said they either felt very comfortable or comfortable.

Governance

Our findings from the other key questions showed that although audits and governance processes and systems were in place many of the systems and processes did not always work effectively in all areas. For example, there was insufficient governance and or oversight in the following areas:

Not all primarily healthcare support workers were using and following the comprehensive care plans, positive behavioural support plans or risk management plans produced by the multidisciplinary team. No one was checking or addressing this issue. 3 out of 5 support staff we spoke with (all agency staff) told us they were not aware that they should have been looking at this documentation and were not aware that supporting peoples with their therapy plans was part of their role.

Although compliance with supervision and appraisal was high at 95% and 94% respectfully, and review of supervision records showed the range of supervision topics discussed was comprehensive, there was no monitoring of staff's skills and competency to perform their roles. If a service does not have robust systems in place to monitor the competency of their staff both verbally and through observation, then they will not know if the delivery of care is high quality or not or indeed if staff are working safely and in line with the services expectations.

Communication between the multidisciplinary team and support staff around changes to peoples care plans, risk plans and positive behaviour support plans was poor. If staff do not communicate changes to people's treatment plans effectively then other staff could be working with people in an unsafe or detrimental way.

Staff did not always complete all clinic audits in line with policy. If governance processes are not robust and not followed routinely and correctly then the manager cannot have full oversight of how the service is performing or feel assured, it is compliant with regulation. Although post inspection the manager sent us some recently completed clinic audits around storage and medicines reconciliation and an action plan to address the findings. We were not assured by this because there had not been sufficient time for the actions to be embedded into practice.

While CCTV was installed throughout the hospital it was organisational policy that it was not routinely checked in live time, only when staff wanted to review specific incidents. If CCTV is not being checked routinely from somewhere like the nursing or managers office, then the manager and nurse leaders cannot see what is happening in the various areas of the hospital and address anything untoward immediately.

However, the service had just appointed a new registered hospital manager. The manager had already identified several areas of practice they could improve as well as introducing additional practice and procedures to strengthen the existing systems used at the hospital. The manager had appointed a Head of care to support her in this.

Wards for people with learning disabilities or autism

Both the Head of Care and new manager were experienced learning disability nurses and have a good reputation within the Cygnet organisation. The manager has successfully implemented similar systems at a sister site to Cygnet Views. Within two weeks of our inspection and in response to high level feedback the manager sent an action plan to address issues we found.

Management of risk, issues, and performance

While the managers addressed issues of poor performance and managed risk well, they did not have full oversight of the skills, knowledge and quality of care given to people using the service by agency staff. This meant that on occasions management of risk outweighed peoples need to develop independence and autonomy.

The manager shared the risk register for the service with us. This showed the manager was aware of risks to the service and the people using it and had acted to reduce these risks.

The manager had worked with CQC the local clinical commissioning group and new Integrated Care Board, as well as the commissioners who had people placed at Cygnet Views. These meetings had covered topics such as risk management of people experiencing episodes of acute mental illness, and their management in an environment that was not suitable for accommodating the needs of people in prolonged acute distress. We saw how the managers had implemented learning from these meetings such as revision of the admissions policy and protocol and model of care. We saw how managers supported by the Integrated Care Board had liaised with referring commissioners and other placements to transfer people who were not benefitting from the care and treatment provided by Cygnet Views, due to their deteriorating mental health.

However, while permanent and bank staff had regular comprehensive supervision, agency staff did not receive supervision from Cygnet views. This meant that managers could not be assured that the agency staff members knowledge, skills and practice were of the standard they expected from their staff.

Permanent and bank staff attended team meetings and received other key information and lessons learned from incidents via individual work e mails. This combined information helped to give them the information they needed to provide safe and effective care. However, agency staff did not receive this information. This meant that not all staff were as informed about people's current care and risk. Although this information was accessible through the people file and grab sheets held in the nursing office, 3 of the 4-agency staff we spoke with told us they either did not know about this information or did not have time before starting their shift to look at it. We were not assured that managers had full oversight of the skills, knowledge and quality of care given to people using the service by agency staff. This meant that on occasion agency staff deferred to a reactive response to managing risk rather than therapeutic pre-empting of the risk and early de-escalation. This impacted on peoples' independence and autonomy at times.

Information management

Although there was some information missing from the routine audit schedules as reported on above, the information staff did collect was analysed and managed well.

All staff had access to the information they needed to deliver safe and effective care. The provider had ensured that more laptops were provided so that all staff had access to these. Staff kept up to date with inputting information so that outcomes and performance could be reported on.

Wards for people with learning disabilities or autism

The service used data systems to collect data that were not over-burdensome for frontline staff.

Information governance systems included confidentiality of peoples' records.

Managers had access to information to support them with their management role. This included information on the performance of the service, staffing, and people's care.

Staff made notifications to external bodies as needed. The registered manager notified the Local Authority safeguarding team, and CQC of incidents. The psychology team were involved in developing a Compassion Focussed Therapy (CFT) Manual in an easy-read format for people with learning disabilities.

Staff gave people all key information, such as their rights, care plans, risk plans, positive behavioural support plans and activity plans in easy read and pictorial formats. Following care and treatment reviews, staff spent time with people to go over information and decisions shared with them at the meetings, to ensure people understood the information.

Engagement

Staff engaged actively in local and national quality improvement activities. Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service took part actively in the work of the local transforming care partnership.

Managers and staff had access to the feedback from people, their relatives and staff and used it to make improvements.

People were involved in decision-making about changes to the service and community meeting records showed this. Staff gave information to people in accessible formats so they could make decisions and choices that affected their care.

People's relatives said they were asked for feedback about the service. Senior managers were visible in the service and people and staff could meet with them to give feedback.

Managers engaged with external stakeholders such as commissioners on a regular basis and provided information and updates in respect of people's progress. Managers and the multidisciplinary team were engaged in people's care and treatment reviews.

Learning, continuous improvement and innovation

The manager was committed to working with the local Integrated Care Board and other stake holders including referring commissioners, and actively sought feedback from them about the care and treatment they were offering to people using the service. Both the Integrated Care Board and managers at the service had good relationships with CQC and wanted to engage with CQC to improve the quality of their service.

We saw that the provider had made significant progress between June 2021 and March 2022. However, between August 2022 and January 2023 managers had not sustained this progress. This had resulted in some areas of the service not maintaining the high standards they had come to expect.

Wards for people with learning disabilities or autism

However, through stakeholder engagement and monitoring the service had recognised the issues at an early stage and put in place measures to address the shortcomings. This included strengthening of the management and leadership team, review of the admission protocol and process and model of care. Managers encouraged a more outward looking focus for the service through closer working links with a sister site of Cygnet Views.

The new manager said that she was keen to use the findings from this inspection to identify other areas that needed addressing. Having engaged in a rigorous monitoring process with the service and sought feedback from the local integrated care board and other commissioners who have people using this service, we are assured that the new manager is responsive to feedback and committed to continuous improvement within Cygnet Views. We have already seen through the action plans sent by the manager, in response to high level feedback following our inspection, how the actions put in place will improve the service in those areas required. While acknowledging that it is too early to measure success because those actions have not had time to become embedded in practice.

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

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Although audits and governance were in place some of the systems and processes had not been used to full effect.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Apart from the new manager and new Head of Care the registered nurses did not have a learning disability background. Registered nurses were not always present in communal areas and were not providing leadership or positive role modelling for healthcare support workers.

Managers were not monitoring support staff's competency or understanding following completion of their online learning disability training. Therefore, some staff were not always confident when working with people with a learning disability and autistic people.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

- The provider must ensure that all staff know the people they are looking after and ensure that staff are engaging with people in a way that encourages people to achieve their potential and ensure all their individual needs were met. Not all temporary staff knew the people they

This section is primarily information for the provider

Requirement notices

were looking after, this prevented staff from interacting with people in a way that encouraged people to achieve their potential and ensure all peoples individual needs were met.

- The provider must ensure that all staff wear clearly identifiable name badges and introduce themselves to people. The provider must ensure that there is a staff identity board in the main communal area of the hospital. People using the service did not always know who the staff were. Staff did not wear clear name badges and there was no staff photograph board in the communal area. This could have prevented people from feeling comfortable enough around staff to exercise their autonomy.
- The provider must ensure that the advocate is able to have access to all people in the communal areas as well as in private while she is on the unit. People could not always access support from independent advocacy. The advocate was not able to be in the communal areas when people were distressed.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- Some staff were not always aware of individual risk. Some support staff were not always following individual risk management plans. While risk management plans were adequate for the person they were intended for, they did not always consider the impact of a person's actions on other people and visitors.
- Due to the design and layout of the hospital the environment was not suitable for people who were experiencing acute mental ill health or who had a history of using fixed ligatures.
- Staff could not control the heating in the communal areas of the hospital. On the day of our inspection the communal areas were uncomfortably hot.
- The provider must ensure that staff are recording how they are checking people's physical health, when the

Requirement notices

person has declined physical observations. There was no evidence to show how staff monitored people's physical health if the person declined physical observations. We reviewed two people's records; one person was on high dose anti-psychotic medicine and the other person required intra-muscular rapid tranquilisation.

- The provider must ensure that all staff follow handwashing procedures all the time. We saw that staff entering and leaving the clinic room to dispense medicines were not washing their hands before or after this process.
- The provider must ensure that staff follow all cleaning procedures all the time, and that all cleaning schedules are present and up to date. Staff had not cleaned the splashback around the sink in the therapy kitchen. Staff had not cleaned a medicines trolley or inside a clinic room cupboard properly. There were no cleaning schedules available for the therapy kitchen or clinic room.
- Staff were not separating people's laundry and it was unclear what was dirty laundry and what was clean. There were no protocols for managing people's laundry.