Cygnet Acer Clinic

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures due to its failure to actively minimise risks to patients, a failure to ensure there were a sufficient number of qualified nursing staff, and due to the failure to effectively identify and learn from incidents, including serious incidents.

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

Professor Edward Baker
Chief Inspector of Hospitals

Overall summary

We undertook a focused inspection of Cygnet Acer Clinic, looking at only the safe and well-led key questions. This inspection was undertaken following a serious incident and other information of concern we received.

We rated safe and well-led at this service as **inadequate**. This means the service is now rated as inadequate overall. The rating for these key questions is limited to inadequate due to the enforcement action we have taken. During this inspection we served notice on the provider under section 31 of the Health and Social Care Act 2008 to urgently impose conditions on the registration of this service. This was due to the serious concerns we found that affected the safety of patients and placed patients at risk of avoidable harm. The urgent conditions included stopping the service admitting any new patients.

We found:

- The service was not safe. The number of incidents of self harm by patients had increased significantly in the three months before the inspection. Almost half of the incidents during that time had involved patients using a ligature. The ligature risk assessments for the wards was too generalised and unstructured and did not include all ligature anchor points on the wards. Service leaders and staff had not effectively minimised the risk of serious harm to patients.
- Over 75% of nursing staff were unqualified. This was not an acceptable skill mix of staff to provide care and treatment to up to 28 patients with complex needs and behaviours. On 60% of shifts there was only one registered nurse on each ward. Senior nursing staff did not recognise that having only one registered nurse on shift, particularly in Upper House, did not provide the skills mix required to support the complex needs of patients.
- On at least four occasions during the inspection patients congregated on the ward, in front of the reception area, banging on windows to attract the attention of staff who were not on the ward. Staff were not available to support patients when they needed them.
- When patients' risks increased this was not always communicated clearly and documents contained different information. The clinical team did not always

Summary of findings

respond appropriately when patient risks were escalating. Patient risks was not always managed well, particularly on Upper House which had seen a dramatic increase in incidents of self harm.

- When staff observed patients intermittently, this was undertaken at fixed times. This meant patients could predict when staff would check on them. This increased the risk of self harm by patients in between those fixed times.
- The wards were large and spread over two floors. With bedrooms on both floors, the layout of Upper House hindered staff observations of patients. Senior staff had not reviewed the environment to identify ways to increase the observation of patients whilst also maintaining their privacy and dignity.
- Staff worked shifts of 12 or more hours per day or night, in some cases, working up to seven days without a day off. Working these hours for four or more days and nights, without a day off, was not best practice, particularly with a patient group with such complex needs and risk behaviours.
- At least two staff who had worked in the service for two or more years had not undertaken face-to-face training on working with people with personality disorders. There was a risk that staff did not have a good understanding of how to work effectively with patients with personality disorders. There was a risk that long-standing staff who had not undertaken this face-to-face training would not be able to fully support newly appointed support workers.
- Leaders in the service did not consistently demonstrate that they had all of the skills and knowledge to manage the service safely. Following a patient death and feedback from a visit by the local clinical commissioning group, the June 2019 ligature risk assessment had a short addendum highlighting one further type of ligature risk. Other ligature risks were not identified or risk assessed. Investigations and reviews of incidents by senior staff had not always maximised the opportunity for learning from these incidents. Important areas of learning were missed.
- There had been no analysis of themes or trends of self harm incidents in the service. These were the most frequent type of incident in the service and such an anaylsis should have been in place.
- A staff whistleblower had contacted the Care Quality Commission in May 2019. Two further whistleblowers contacted us during the inspection. They reported low staffing levels, a lack of support from managers, and a lack of action by managers when they raised concerns.

However:

- There were clear processes for dealing with complaints, monitoring safeguarding referrals and making statutory notifications to the Care Quality Commission.
- Although staff restrained patients 91 times in the three months before the inspection, none of these restraints were in the prone position. This followed best practice guidance due to the risks to patients when restrained in the prone position.
- Patients were able to progress to self medicate on Upper House and Lower House. This involved a clear system of multidisciplinary reviews to ensure any risks to patients were minimised.
- Following the imposition of conditions on the provider they conducted an analysis of self harm incidents including themes and trends. When we returned to the service on 28 August for the last day of this inspection we saw that the provider was acting on this information to minimise incidents when they were most frequent. The provider also took other immediate action concerning staffing levels, staff training, the environment and the risk management of patients.

Summary of findings

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Summary of this inspection

Background to Cygnet Acer Clinic

Cygnet Acer Clinic provides care and treatment for 28 female patients with personality disorder and who self harm. Some patients also have a mental illness, learning disability, substance misuse problems or an unrelated physical health condition. The service has 28 beds, 14 beds on Upper House and 14 beds on Lower House.

Cygnet Acer Clinic is registered to provide:

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

Treatment of disease, disorder or injury.

There was a registered manager in post at the time of this inspection.

Cygnet Acer Clinic has been inspected three times since 2015. The service was last inspected by the Care Quality Commission in October 2018 when the service was rated as good overall.

The safe key question was rated as requires improvement and we issued two requirement notices. These told the provider that they must ensure the ligature anchor risk assessment was reviewed and updated following changes to the environment or use of the environment. We also told the provider they must ensure all staff providing care or treatment must have the qualifications, competence, skills and experience to do so safely. This requirement had not been met.

Our inspection team

This inspection was undertaken by five CQC inspectors and a CQC specialist advisor who was a registered nurse with experience of working with women with personality disorders.

Why we carried out this inspection

This was a focused inspection undertaken following a serious incident involving a ligature and resulting in a patient death. This followed a similar patient death in 2018.

The Care Quality Commission had also received information concerning the safety of patients at Cygnet Acer Clinic.

How we carried out this inspection

As this was a focused inspection we only inspected the following key questions:

- Is it safe?
- Is it well-led?

During the inspection visit, the inspection team:

- visited the service and looked at the quality of the environment
- spoke with 14 patients who were using the service
- spoke with the registered manager and heads of care for each ward
- spoke with 17 other staff members; including a doctor, registered nurses, support workers, an occupational therapist, a psychologist, and a Mental Health Act administrator
- spoke with the provider's clinical director and director of nursing
- looked at 10 care and treatment records of patients

Summary of this inspection

- attended a multidisciplinary morning meeting and a nursing handover
- looked at six staff human resources records
- looked at a range of policies, procedures and other documents relating to the running of the service
- we also spoke with one of the commissioners of the service before the inspection and a further commissioner during the inspection visit.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate 

We rated safe as inadequate because:

- The service did not provide safe care. The number of incidents of self harm by patients had increased significantly in the three months before the inspection. On Upper House, this had increased from 156 incidents in May 2019 to 577 incidents in July 2019. Leaders and staff in the service did not minimise the risk of serious harm to patients.
- Over 75% of nursing staff were unqualified. This was not an acceptable skill mix of staff to provide care and treatment to up to 28 patients with complex needs and behaviour. On 60% of shifts there was one registered nurse on each ward. This had an impact on patients being able to obtain the right support when they were distressed or their risks had increased.
- When patients' risks increased this was not always communicated clearly and documents contained different information. The clinical team did not always respond appropriately when patient risks were escalating. When there were signs that patients risks of serious self harm were increasing staff did not take action to minimise those risks.
- Eighty percent of staff had undertaken training in self harm and suicide awareness. In 2019, there had been two serious incidents, one of which led to a patient death by using a ligature. Twenty per cent of staff had not been trained to understand the most common types of incidents, one of which had fatal consequences.
- When staff observed patients intermittently, this was undertaken at fixed times. This meant patients could predict when staff would check on them. This increased the risk of self harm by patients in between those fixed times and did not follow Mental Health Act 1983 Code of Practice guidance (2015).
- The wards were large and spread over two floors. With bedrooms on both floors, the layout of Upper House hindered staff observation of patients. This meant staff were not always available in communal areas to support patients.

Summary of this inspection

- Staff worked shifts of 12 or more hours per day or night, in some cases for up to seven days without a day off. Working these hours for four or more days and nights, without a day off, was not best practice, particularly in view of the challenges of working with the patient group in the service.
- Some staff had been working in the service for two or more years and had not undertaken face-to-face personality disorder training. There was a risk that staff did not have a good understanding of how to work with patients with personality disorder. Four patients said that some staff members' attitudes could be dismissive following self harm incidents.

However:

- New staff had a two week induction when they started working in the service. This included training and 'shadowing' experienced staff. This time allowed new staff to understand how the service worked and to meet patients.
- Patients were able to progress to self medicate on Upper House and Lower House. This involved a clear system of multidisciplinary reviews to ensure any risks to patients were minimised. Self medication was part of patients progress to discharge from hospital.
- When patients were restrained by staff none of these incidents involved patients being restrained in the prone position. This followed best practice guidance by avoiding the risks associated with restraining patients in the prone position.
- Following the imposition of conditions on the provider they took action concerning staff training, the environment, and the risk management of patients.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- Leaders did not have the skills and knowledge to manage the service safely.
- Following a patient death and feedback from a visit by the local clinical commissioning group, the June 2019 ligature risk assessment had a short addendum highlighting one further type of ligature risk. Other ligature risks were not identified or risk assessed.This meant that ligature anchor points in the environment had not been appropriately assessed and staff were not aware of the potential risks. Leaders did not ensure risks to patients were minimised.

Summary of this inspection

- Investigations and reviews of incidents by senior staff did not always maximise the opportunity for learning from these incidents. Important areas of learning were missed. These included a detailed review of incidents leading up to a serious incident.
- Leaders in the service had not provided clear direction for staff when the frequency of self harm incidents on Upper House increased dramatically. Leaders were committed to a rehabilitation and positive risk taking model. However, this meant that risk was not always managed well. The balance between positive risk taking and the active management of increased risks was not safe, particularly on Upper House.
- There had been no analysis of themes or trends of self harm incidents in the service. These were the most frequent type of incident in the service and such an analysis should have been in place. This meant leaders and staff were not aware of what measures could be effective in reducing the number of incidents.
- Senior nursing staff did not recognise that having only one registered nurse on shift on the wards, particularly Upper House, did not provide the skills mix required for the complex needs of patients. This had an effect on patients' ability to obtain appropriate support when they were distressed and their risks of self harm had increased.
- A staff whistleblower had contacted the Care Quality Commission in May 2019. Two further whistleblowers contacted us during the inspection. They reported low staffing levels, a lack of support from managers, and a lack of action by managers when they raised concerns.

However:

- There were clear processes for dealing with complaints, monitoring safeguarding referrals and making statutory notifications to the Care Quality Commission.
- Following the imposition of conditions, the provider had completed an analysis of self harm incidents included themes and trends. The provider acted on this information to minimise incidents when they were most frequent.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Well-led	Inadequate

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

Inadequate

Safe and clean environment

At our previous inspection in October 2018, we found that staff in the service had not updated ligature risk assessments following a change in the use of rooms. We served a requirement notice on the provider to ensure the ligature risk assessment was updated. At our previous inspection, staff had told us that the provider was in the process of updating its ligature assessment framework. At this inspection, we found different areas of concern regarding ligature risk assessments.

Upper House and Lower House were clean and had good furnishings. Cleaning staff worked from Monday to Friday to ensure the wards were clean. At weekends nursing staff undertook cleaning tasks. The ward areas were well maintained. There were closed-circuit television cameras (CCTV) in some communal areas of the service and externally. However, not all of the communal areas of the wards had CCTV coverage. During the inspection, maintenance staff were undertaking work to seal gaps in wall mounted equipment, such as thermostatic controls, to prevent them being used as ligature anchor points.

During this inspection, we found that following a patient death and feedback from a visit by the local clinical commissioning group, the June 2019 ligature risk assessment had a short addendum highlighting one further type of ligature risk. Other ligature risks were not identified or risk assessed. The ligature risk assessments for both wards were an unstructured assessment by the staff member completing it. We found a number of ligature anchor points on both wards which were not included in the ligature risk assessments. These included anchor points which patients had previously used to attach a ligature. There was a risk that staff were not aware of these additional ligature risks and the level of risk they posed had not been assessed.

On our third day of inspection, after we had imposed conditions on the provider, we reviewed the ligature risk assessments again. Staff had been trained how to undertake ligature risk assessments and had developed updated ones using the Manchester ligature audit tool; a tool to objectively assess the risk of ligature anchor points in the environment. The new ligature risk assessments were structured, detailed and comprehensive. A significant number of previously unidentified ligature anchor points were recorded on the new risk assessment. These included bathroom fixtures and fittings and television cables. However, the mitigation for a number of ligature anchor points was recorded as staff to be present or regular observation. This mitigation was recorded for a room where two patients had recently removed a ligature from another patient before staff arrived. It also included a room where a television cable had previously been used by a patient as a ligature. It was not clear that the combination of availability of staff and the challenges of the environmental layout of the ward was sufficient to minimise these ligature risks. The new ligature risk assessments recorded actions to be taken to minimise some ligature risks. However, there were no dates for the actions to be completed.

At our inspection we were made aware that a patient on Lower House had tied a ligature in a maintenance cupboard which was off the ward activity room. This cupboard housed mains electricity cables, a chair and other cables. Staff thought the patient had left the ward. In response to this incident the head of care told us that the maintenance cupboard and activity room would be subsequently locked. Staff were informed by email and in the morning meeting about the incident. However, during the inspection, a member of the inspection team found the activity room open. A staff member told us they were unaware that this door should remain locked.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Lower House was a ward on two floors, with bedrooms on the lower floor. Upper House was also on two floors with bedrooms on both floors. Both wards had a large floor space with long corridors. There were no convex mirrors in place for staff to see around corners in the layout. This restricted what staff could observe unless they were physically present. The large ward area, split over two floors, particularly on Upper House, hindered observation by staff. On occasions during the inspection, members of the inspection team stood in the main corridor for at least ten minutes. On occasions patients were also in this area banging on windows to attract the attention of staff. No staff were seen during this time. On the last day of inspection, convex mirrors had been fitted to enable staff to more easily observe parts of the wards. However, there were still periods of time when there were no staff in communal areas or corridors.

There were hand sanitisers at the entrance to each ward. Clinical waste bags were used to dispose of clinical waste and sharps bins were available for needles and sharp objects. Four patients told us that they shared cutting implements, such as razor blades, and that staff allowed this to happen. This was an infection control risk.

The clinic rooms on each ward were clean and well organised. Medical equipment, such as the electronic sphygmomanometer (blood pressure machine) had been calibrated. This ensured they provided accurate readings. Resuscitation equipment for both wards was regularly checked and in order. Unannounced resuscitation practice scenarios took place. This was an opportunity for staff to respond to practice emergencies and familiarise themselves with resuscitation equipment.

Safe staffing

The ward managers on Lower House and Upper House were called Heads of Care and were both registered nurses. The service had three senior nurses and eight registered nurses. At the time of the inspection, a senior nurse and two registered nurse posts were vacant. The service also had 42 support workers of varying grades of seniority. There were seven support worker posts vacant (17% of posts). The support worker posts had been recruited to and recruitment checks were being completed. The staffing establishment for the service meant that over 75% of nursing staff were unqualified. This was not an acceptable skill mix of staff to provide care and treatment to up to 28 patients with complex needs and behaviour. It did not acknowledge the relationship between safe staffing levels, skills mix and quality of care (Future nurse: standards of proficiency for registered nurses, Nursing and Midwifery Council, 2018). The hospital manager told us they had reviewed staffing levels recently. The provider's director of nursing was already involved with a provider-wide review of nursing staffing levels.

Almost all staff worked on both Lower House and Upper House. There were three separate staff rotas for different types of nursing staff working on both wards. These rotas covered different time periods and were completed by different staff members. They did not always reflect the actual staffing on the wards according to the daily allocation records. The system of rotas was complicated and added confusion and the potential for mistakes concerning staffing of the wards.

Staff worked twelve hours during a day shift and thirteen hours on a night shift. Three registered nurses were rostered to work per shift. One registered nurse would be allocated to each ward and the third would be 'floating'; attending whichever ward required them. However, from June to August 2019, 60% of shifts had two registered nurses; one for each ward. In addition, seven or eight support workers were rostered to work each shift; three or four for each ward. The staffing levels for support workers were met on each shift.

Bank and agency staff were used when required to cover vacant posts. However, there was little use of agency staff as the service had a number of bank staff. Heads of care could also request extra staff if required, for example to cover long escorted leave with a patient. A number of regular staff undertook additional bank shifts. This meant that some staff regularly worked four days or nights consecutively, without a day off. In some cases, staff worked up to seven consecutive day or night shifts without a day off. The hospital manager had obtained advice from the provider's human resources department regarding rest days. However, this advice referred to the legal position. Working 12 or more hours for four or more days and nights, without a day off, did not follow best practice guidance (Managing shiftwork: health and safety guidance, Health and Safety Executive, 2006). This was particularly the case in view of the challenges of working with the patient group in the service.

New staff had an induction when they started working in the service. This included orientation to the service and

introductory sessions on communication, risk management and policies and procedures. New staff also 'shadowed' other staff during the induction period which lasted two weeks.

Nine patients said that staff were not always available when they needed them. Six patients said that they supported each other due to a lack of staff. On Upper House, on at least four occasions, patients congregated on the ward in front of the reception area, banging on windows to attract the attention of staff who were off the ward. Staffing levels on the wards, particularly Upper House, did not reflect the complex needs and risk behaviours of patients. When one registered nurse was working, this meant patients did not receive timely and effective care which focused on the safety of patients.

The activity calendar recorded a full programme of activities every day of the week.

Seven patients on Upper House said there was a lack of structured activities and those planned were often cancelled. Recent records of patient activities recorded that 79% of patients had a minimum of 25 hours of 'meaningful activity' per week. However, this included 15 minutes each time patients took medicines and one and a half hours for eating per day for each patient. A further 30 minutes activity was recorded for attending the daily patients meeting. This meant there was an automatic minimum of 14 hours 'meaningful activity' per week recorded for all patients. Other activities recorded were for self care, leisure or one to one meetings with staff. During the three days of inspection we observed that patients were not regularly involved in activities. Most planned activities were in the community and could only be accessed by patients with leave from the hospital. Staff told us that the recording of activities was not correct due to new staff not understanding what needed to be recorded.

In May 2019, a patient contacted CQC and described the service being short of staff. The patient told us there were not enough staff to take them to the local general hospital for treatment following an incident of self harm. The patient said this was not the only occasion that this had happened. Prior to the inspection, three patients needed to attend the general hospital following incidents of self harm. There were not enough staff to ensure this was undertaken in a timely way. A staff whistleblower contacted CQC during the inspection and informed us of this. This was confirmed by a patient.

There were mixed reports concerning the frequency of one to one meetings between patients and their named nurse. Some patients reported that these happened frequently and others reported there were not enough staff for weekly one to one meetings. Two patients' care records on Upper House showed that one to one meetings with patients did not always happen weekly.

A full time consultant psychiatrist worked in the service and was the consultant for all of the patients. This consultant was also the provider's medical director for the North East of England. A staff grade psychiatrist also worked full time in the service. Outside of normal weekday work hours there was no doctor on-site in the service. A staff grade doctor in the region was on-call and able to come in to the service during those times.

At our previous inspection in October 2018, we found that some staff did not have the necessary qualifications, competence, skills or experience to provide care and treatment to patients. We issued a requirement notice telling the provider to remedy this. At this inspection, training records recorded that staff had undertaken 12 types of mandatory training. All registered nurses had additionally undertaken intermediate life support training. Mandatory training included personality disorder training and responding to emergencies. However, only eighty per cent of staff had undertaken self harm and suicide awareness training. The remaining 20 per cent of staff were booked to undertake this training within the month following inspection. This meant that, at the time of the inspection, one fifth of staff had not undertaken training concerning the most common types of patient incident, one of which had led to the death of a patient in 2019.

Mandatory personality disorder training for staff was online. There was also separate face to face training on working with people with a personality disorder. However, the hospital manager told us that there were lower levels of completion for this training. A registered nurse and a support worker we spoke with had not undertaken this training. Both had worked at the service for two or more years. There was a risk that staff did not have a good understanding of how to work with patients with a personality disorder and work effectively to promote patient safety.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Following the imposition of conditions, all staff were being trained in personality disorder awareness (face to face training) and self harm, suicide and risk training. The plan was for all staff to be trained by the end of September 2019.

Assessing and managing risk to patients and staff

Patients being treated at the service had a range of potential risk behaviours, including self harm. Many patients had been transferred from other hospitals who were unable to manage these risks. Patients were initially admitted to Upper House. When they were more stable, with a reduced level of risk, they transferred to Lower House.

Patients' potential risk behaviours were assessed when they were admitted to the service. Staff used the short-term assessment of risk and treatability (START). This is a recognised tool to assess a range of potential risks. Patients' START assessments were thorough and detailed.

Each weekday morning the multidisciplinary team met to discuss patients and any incidents. On Upper House, incident forms and management plans did not always contain the same information. Some incidents of patients' self harm were not recorded in the daily risk assessment or updated in their START risk assessment.

A sample of minutes from the morning meetings showed that patients' risk management plans and observation levels remained unchanged, irrespective of the number and type of incidents involving a patient or other risk information. These statements appeared to be 'cut and pasted' onto the morning meeting minutes. One of the provider's senior managers also found this when they visited the service after the first two days of inspection.

Patients were also given a risk rating using the red, amber, green (RAG) risk rating system. The RAG rating of individual patient risks did not correspond as expected with their observation levels. Patients demonstrating a clear escalation in their level of risk remained on intermittent observations by staff. One patient's use of ligatures resulted in them repeatedly being found with facial discolouration. This indicated oxygen was not reaching the patient's head or brain. The patient's observation levels were unchanged for some time before they were eventually increased. On another occasion, a different patient's use of a ligature resulted in blood vessels in their face rupturing. Their observation level remained unchanged. Two days later they used a ligature anchor point to suspend themselves from the floor. The patient required cardiopulmonary resuscitation and a period of time in intensive care. The patient subsequently had a degree of acquired brain injury.

Following the imposition of conditions on the provider, on the last day of inspection all patients' levels of risk had been reassessed. However, there continued to be discrepancies in recording patients level of observations to manage risks. A patient's risk assessment stated that the patient was observed by staff continuously at arms length for four days. In the patient's care records intermittent observation of the patient every 30 minutes was recorded throughout that time. A different patient was involved in several self harm incidents, including cutting their neck with glass. They were recorded as being low in mood with some suicidal ideas. The patient's observation level remained intermittent every 30 minutes. Their RAG rating was red, indicating the patient was at high risk. Patients' observation levels did not reflect their RAG rating. A further patient was recorded as being on hourly observations by staff. Their observation record showed they were being observed every 15 minutes.

The number of incidents of self harm by patients in the hospital had increased significantly in the three months before the inspection. In May 2019, on Lower House there had been 59 incidents, of which 17 involved a ligature. In the same month, there were 156 incidents on Upper House, with 63 involving a ligature. In June 2019, of 77 incidents on Lower House, 18 involved a ligature. On Upper House there were 335 incidents, of which 130 involved a ligature. In July 2019, the number of incidents on Lower House decreased and there were 55, 12 of which involved a ligature. On Upper House, in July 2019, there were 577 incidents, of which 340 involved a ligature. These incidents involved 11 patients on Upper House, of which nine had used a ligature at least once. Half of the patients on Upper House were involved in more than 10 incidents of self harm in July 2019.

All nursing staff carried a bag on their waist. This bag contained two types of ligature cutters and a pair of wire cutters. The wire cutters were to snap the metal in bras if they were used as a ligature.

The provider's observation policy clearly defined the different levels of staff observation of patients. It referred to the Mental Health Act 1983 code of practice. However, the policy did not clearly state that intermittent observations

should be undertaken by staff in an unpredictable way. Staff undertaking intermittent observations of patients did so at fixed times on the hour, a quarter past the hour, half past and at a quarter to the hour. Patients were aware when staff would be undertaking intermittent observations. This increased the risk that patients would engage in risk behaviours in between those times. In addition, staff did not always record when they had undertaken observations of patients. There were a number of gaps in the observation records, including for a patient who was continuously observed by staff. On one occasion there was a gap of five hours where there was no record that a patient had been observed by staff.

On the third day of inspection, following the imposition of conditions, all staff had been trained in how to undertake observations. The provider had also observed staff to ensure intermittent observations were taking place in an unpredictable way. However, there continued to be some gaps in observation records, and some patient observations continued to be recorded at fixed times. We saw that one patient had self harmed twice in between the fixed times that staff undertook intermittent observations. After the inspection, four patients on Upper House had their observation levels increased to continuous observation by staff.

The ethos throughout the service was to promote positive risk taking; carefully balancing risks, empowering patients and the responsibilities of the treating team. Four patients said how this was carried out was not safe. A staff member told us that when patients used ligatures this was not always with the intention of ending their life. They said this was why the service should see a high number of risk incidents. A relatively new member of staff told us there had not been many incidents on Upper House in the previous two days. There had been 16, including five incidents involving ligatures. None of the staff we spoke with during the inspection raised patient safety as an issue. Staff clearly understood the concept of positive risk taking. However, they did not always recognise that patients' intentions when self harming did not equate to the level of risk involved. Through experiencing a high level of incidents where patients self harmed, some staff had developed a degree of complacency towards incidents of self harm, and specifically ligature incidents. The balance between positive risk taking and the active management of increased risks was not safe, particularly on Upper House.

Eight patients told us they did not feel safe on Upper House regarding their own self harm. Five patients said staff did not provide them with enough support after they had self harmed. Four patients said that some staff members' attitudes could be dismissive following self harm incidents. Staff said that after incidents of self harm patients were supported and were debriefed. However, three patients said that in their experience post-incident debriefs did not always happen.

The provider had a search policy. This policy referred to guidance in the Mental Health Act 1983 code of practice. There was no system of routine searches of patients, their property or their room, as described in the policy. Records of searches showed that the frequency of searches of individual patient's, their property or room varied. They ranged from up to three times in a month to once every two months. The frequency of patient searches was consistent with the provider's policy of minimal restrictive practices. However, two patients told us that restricted items were brought into Upper House by patients due to inconsistent searches. This had included a patient bringing paracetamol tablets onto the ward, which may have been used for a patient to overdose.

There were very few blanket restrictions in the service, consistent with the rehabilitation model of the service. Items such as adhesive tape, carrier bags and cans were restricted. However, glass items were not. In addition, the restricted items list included lighters. Informal patients on Lower House could keep their own lighters. The restricted items list did not reflect the function of each ward or the increased levels of risk of patients on Upper House.

The wards were smoke-free. Patients could smoke in the garden on each ward. Staff also smoked in the garden and senior staff told us that it was the provider's policy that staff could smoke on-site. On several occasions during the inspection staff congregated in the ward garden areas to smoke cigarettes. This took staff away from their work with patients and did not reflect best practice in healthcare services.

Informal patients on Lower House could leave the ward whenever they wished.

In the three months before the inspection, there had been 91 incidents of restraint in the service. Twenty-one of these restraints were of patients on Lower House, with 70 on Upper House. None of these incidents involved restraining

patients on the floor or in the prone position. This followed best practice guidance that staff should avoid prone restraint, wherever possible, due to the risks associated with the prone position (Positive and proactive care, Department of Health, 2014).

All staff in the service had undertook training in safeguarding adults and children. The hospital social worker was the safeguarding lead for the service and a record was kept of all safeguarding referrals made to the local authority. The hospital manager had recently conducted additional safeguarding training with all staff. Staff were aware of circumstances that may require a safeguarding referral and knew what action to take. The service had made a number of safeguarding referrals to the local authority. Some of these referrals concerned the disclosure of historic abuse by patients. The service had a good working relationship with the local authority safeguarding team.

During the inspection, the inspection team took the unusual step of making a safeguarding referral to the local authority. This reflected our serious concerns regarding the service and patients being exposed to the risk of avoidable harm, including serious harm.

The service recorded patient information on both a paper system and an electronic system. Overall, appropriate information was available for staff to provide care and treatment to patients. However, risk information concerning patients varied between morning meeting minutes, incident forms and patient care records. This meant the changing level of patient risk was not always communicated effectively. This affected the safety of patients.

Medicines were stored appropriately and at the correct temperature. There was an established system for ordering medicines. Medicines were prescribed and administered in accordance with patient's consent (T2) or authorisation (T3) certificates. On Upper House, liquid medicines did not have the date recorded when the bottle had been opened. This meant the medicines may start to lose their effectiveness if left opened over time. On Upper House and Lower House there was a system for patients to self medicate. This involved regular reviews by the multidisciplinary team and a gradual increase in the amount of medicines a patient could keep with them.

Track record on safety

There had been three serious incidents in the service in 2019. One of these had involved the death of a patient following use of a ligature anchor point. Two other serious incidents involving ligatures were reported. One of those two patients sustained a degree of acquired brain injury following the incident.

A further incident in January 2019 involved an escorted patient leaving a general hospital where they were receiving treatment following an incident of self harm. The patient was subsequently found by police in an isolated area and the ligature they had made was removed. The patient was reported to be initially unresponsive. A 72 hour report for this incident was completed. However, this incident should have been classified as a 'near miss'. The seriousness and circumstances indicated that a serious incident investigation would have identified further learning beyond that which the 72 hour report did.

In addition to this incident, the provider's serious incident policy indicated that a series of incidents affecting standards of safe care may be investigated as a serious incident. The dramatic increase in self harm incidents from May to July 2019 on Upper House, had not led to a serious incident investigation.

In the three months prior to the inspection 1,512 incidents were reported. The most commonly reported were self harm (1,256), violence (96) and medicine incidents (74).

Reporting incidents and learning from when things go wrong

There was a well-established culture of reporting incidents in the service. A range of incidents were reported included potential abuse, accidents, violence and security incidents. Staff knew what type of incidents to report.

Staff received feedback from incidents in a number of ways. This included debriefing after incidents and in the multidisciplinary morning meetings. However, learning from incidents, including serious incidents, was not consistent.

In April 2019, a patient used a ligature anchor point resulting in a degree of acquired brain injury. The draft serious investigation report highlighted two areas of learning. One concerned a staff member and the other concerned levels of observation when patients were admitted. The investigation report failed to describe incidents prior to the serious incident. This included an

Long stay or rehabilitation mental health wards for working age adults

Inadequate

incident two days previously when the patient's use of a ligature resulted in ruptured blood vessels in their face. This should have indicated a serious risk of harm to the patient but the patient's risk management plan and observation levels were unchanged.

Other incidents did not lead to learning for the staff team. Following the death of a patient in July 2019, ligature risk assessments were not updated and did not identify all ligature risks in the ward environments. There had been incidents on Upper House in communal areas, such as the quiet room when two patients removed a ligature before staff attended. The new ligature risk assessment stated risks in this room would be minimised by staff observation. The number and type of incidents on Upper House had not led to a review of the restricted items patients were prevented from having on the ward. On Lower House, following an incident, a decision was made for the activity room and maintenance cupboard off this room to remain locked. However, our inspection team saw that this was not the case when we returned to the service for our last day of inspection. We also spoke to a staff member was not aware it should have been locked.

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

Inadequate

Vision and values

The vision of the service was to enable each patient to reach their own personal best. Staff throughout the service shared this vision.

Staff were committed to the model of rehabilitation and positive risk taking in the service. Overall, this model worked well on Lower House and there were clear signs of the rehabilitation ethos. However, the rehabilitation and positive risk taking model on Upper House did not reflect the level of increasing risk incidents up to the time of the inspection. Two patients and a staff member spoke of Upper House being like an acute admission ward or psychiatric intensive care unit. The rehabilitation and positive risk taking model on Upper House had taken precedence over the active management of patient risks.

Good governance

There were established systems for complaints, safeguarding referrals and statutory notifications to the CQC. The monthly governance meeting recorded the number and type of incidents, including incidents of restraint. This information also recorded which patient on each ward had self harmed and the type of self harm. Leaders had not implemented a thematic and trend analysis of self harm incidents in the hospital. Self harm was a key risk factor for patients admitted to the hospital and self harm incidents were recorded every month. An analysis of themes and trends should have been in place for the most frequent incident type in the service. An analysis of themes and trends was completed following the imposition of conditions on the provider by CQC.

Investigations and reviews of incidents by senior staff did not always maximise the opportunity for learning from these incidents. Important areas of learning were missed. At least two incidents had not been categorised or investigated in accordance with the provider's incident policy.

The governance system had not identified the serious safety issues regarding how staff undertook observation of patients, the appropriateness of the ligature assessment tool, or how effectively patient safety and risk issues were communicated amongst the staff team. There was a lack of effective benchmarking with other services, to learn how to make systems more effective in identifying and proactively addressing safety concerns.

Whilst there had been ongoing efforts to recruit and retain nursing staff, senior staff did not recognise that having one registered nurse on shift on the wards, particularly Upper House, did not provide the skill mix required for the complex needs of patients. Nursing staff levels had been reviewed by the hospital manager before the inspection. This review had not recognised that patients were not receiving the care they required in a timely way on Upper House. Staff and resources were not managed effectively (NMC briefing: Appropriate staffing in health and care settings, Nursing and Midwifery Council, 2016). In addition, there had not been appropriate focus on the number of days and nights staff worked without a day off.

The last CQC inspection in October 2018 led to CQC issuing two requirements notices concerning the ligature risk assessments and the qualifications, knowledge, skills and

experience of staff. At this inspection, CQC continued to have concerns regarding these areas. Appropriate action had not been taken to improve these areas, and to maintain that improvement.

Senior staff had not reviewed the environment to identify ways to increase the observation of patients whilst also maintaining their privacy and dignity.

A serious incident in April 2019 resulted in a patient acquiring a degree of brain injury. This was investigated by the hospital manager. The provider's serious incident policy indicated that this investigation should have been a comprehensive internal investigation with a professional external to the hospital being involved.

Leadership, morale and staff engagement

Clinical and operational leaders in the service did not demonstrate they had all of the skills and knowledge to manage the service safely. The June 2019 ligature risk assessments did not include all ligature anchor points, were too generalised and subjective. Following a patient death and feedback from a visit by the local clinical commissioning group, the June 2019 ligature risk assessment had a short addendum highlighting one further type of ligature risk. Other ligature risks were not identified or risk assessed. Nursing leaders chose to wait until the provider completed a review of how ligature risk assessments were undertaken in the organisation. This placed patients at increased risk of avoidable harm as no changes were made to improve safety.

Leaders in the service had not provided clear direction for staff when the frequency of self harm incidents on Upper House increased dramatically. Leaders were committed to positive risk taking and a rehabilitation model, but this meant risk was not always managed well. Basic measures to try and minimise risks were not implemented. Restrictions on patients' personal items were the same on both wards and there was an extreme reluctance for patients to be observed by staff continuously. Leaders in the service believed they managed patient risks well, in the face of contradictory evidence.

The provider's senior leadership team had visited the service more frequently before the inspection. These visits had not identified and addressed the systemic and practical safety issues identified during this inspection. There was a lack of recognition that the leadership team in the service were unable to effectively monitor and manage the escalating number of incidents in the service.

Overall, staff spoke positively about the leaders in the service. They felt supported in their role and found managers to be visible and accessible. Staff were proud of the work they did and felt able to raise concerns without fear of retribution. However, CQC were contacted by a staff whistleblower in May 2019. They reported low levels of staffing. During the inspection, CQC were contacted by two staff whistleblowers. They reported low staffing levels, a lack of support from managers and that when concerns were raised to managers there was no action. They spoke of the increase in patient risk and that patients did not feel safe.

Commitment to quality improvement and innovation

The service was not taking part in any quality improvement or independent accreditation scheme.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there are sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff at all times to meet the needs of patients.
- The provider must undertake an assessment of the safety and welllbeing of each patient, which should include a comprehensive review of risk assessments, risk plans and levels of observation to ensure patient safety.
- The provider must undertake a comprehensive review of the daily meeting system for discussing and recording patient incidents and risk management.
- The provider must urgently address how lines of sight on corridors are mitigated by staff and ensure that convex mirrors in blind spots are introduced where appropriate, ensuring objects constituting a ligature risk are removed.
- The provider must undertake a comprehensive ligature assessment demonstrating how the risks are being mitigated.
- The provider must ensure that all staff have completed training in personality disorder, suicide prevention and self-harm management, carrying out of observations and undertaking ligature assessments.
- The provider must ensure that incident patterns and trends are analysed to show an individual and unit picture e.g. time, location, type, so as to inform staff to make managerial decisions.
- The provider must ensure patients have therapeutic and meaningful activity and ensure that staff accurately record the uptake of activities.
- The provider must ensure they review and manage staff shift patterns, monitor excess hours and ensure that staff have sufficient rest days built into shift patterns, including volunteer staff.
- The provider must review and evidence learning from serious incidents and actions taken to improve safety within the unit and ensure that learning is shared with all grades of staff.
- The provider must review the observation policy and audit how it is being implemented.
- The provider must take steps to minimise infection control risks by patients sharing sharp objects to self harm. Regulation 12(2)(h)
- The provider must ensure that patients are prevented from accessing the maintenance cupboard on Lower House. Regulation 12(2)(b)

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(b)(h)**