Cygnet Hospital Colchester

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

Overall summary

- Staff did not always follow the provider's Covid-19 policy or infection prevention and control guidelines set out by the government. Staff did not always wear face masks, some staff wore them inappropriately and did not always dispose of them correctly. This posed a risk that patients, staff or others could transfer infection.
- Managers failed to monitor staff wearing face masks appropriately and failed to take appropriate action when staff breached infection prevention control guidance. We also found that managers failed to monitor the appropriate disposal of clinical waste in some areas.
- Managers had not taken every step to ensure they recruited staff that had the right skills, experience and values to work with a vulnerable patient group. Of a sample of 38 staff employment records we looked at, 25 (66%) did not follow the provider's recruitment, selection and appointment of staff policy.
- Managers had not assured themselves that staff practice during restraint was appropriate. The providers guidance on the volume of closed circuit television to review was unclear. We were not assured that managers completed a sufficient number of closed circuit television reviews to evidence staff safely restrained patients.

However:

- We reviewed 79% of all available closed circuit television linked to restraints across all wards, between 19 July and 18 August 2020. We observed staff using restraint techniques effectively and staff managed most incidents well. Managers held staff and patient debriefs and were supported after any serious incident. Managers shared learning from serious incidents with their staff, both internal and external to the service.
- We saw examples and patients told us staff treated them with kindness and respect. Staff were available when patients needed them.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units		Highwoods ward has 19 beds and is an acute in-patient service.
Long stay or rehabilitation mental health wards for working-age adults		Ramsey ward is the largest ward with 21 beds and is a high dependency inpatient rehabilitation service.
Wards for people with learning disabilities or autism		Oak court has 10 beds for patients with a learning disability, associated complex needs and behaviours that challenge. Larch court has four beds and provides intensive support for patients with autism, learning disabilities and complex needs.

Summary of findings

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Location name here

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Long stay or rehabilitation mental health wards for working-age adults; Wards for people with learning disabilities or autism

Summary of this inspection

Background to Cygnet Hospital Colchester

The location Cygnet Hospital Colchester is a 54-bed hospital for men aged 18 years and above based in Colchester, Essex. The provider is Cygnet Learning Disabilities Ltd.

There are three core services:

Acute wards for adults of working age

• Highwoods ward has 19 beds and is an acute in-patient service.

Long stay rehabilitation mental health wards for working age adults

• Ramsey ward has 21 beds and is a high dependency inpatient rehabilitation service.

Wards for people with a learning disability or autism

• Oak court has 10 beds for patients with a learning disability, associated complex needs and behaviours that challenge. Four beds are for patients in short term crisis or those who no longer require acute care but remain on an acute ward. Five beds are for patients with high dependency needs and supports assessment, treatment and rehabilitation. There is a one bed apartment to provide a more independent living environment.

• Larch court has four beds and provides intensive support for patients with autism, learning disabilities and complex needs.

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

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

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

• Treatment of disease, disorder or injury.

At the time of the inspection the location did not have a registered manager. The provider had submitted an application for the hospital manager to become registered. The provider is submitting an application for a controlled drugs accountable officer.

The Care Quality Commission carried out a focused inspection at this location on 10 and 11 March 2020 to check on the provider's action regarding a section 29 warning notice regarding a breach of Regulation 13 safeguarding service users from abuse and improper treatment. The provider had taken action address the warning notice. However, breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified for:

• Regulation 17 Good governance

• Regulation 18 Staffing

At the last rated comprehensive inspection 12, 13, 14 and 20 November 2019 we found the provider had taken actions to make improvements, but we identified breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for:

• Regulation 9 Person centred care

• Regulation 12 Safe care and treatment

• Regulation 17 Good governance

The provider sent the Care Quality Commission their action plans outlining how they would address the breaches of regulations. Additionally, we identified a breach of Regulation 13 safeguarding service users from abuse and improper treatment and issued a section 29 warning notice to the provider.

The Care Quality Commission carried out a focused inspection on Flower Adams 1 and 2 wards at this location on 9, 15 April and 2 May 2019. Breaches of The Health and Social Care Act

2008 (Regulated Activities) Regulations 2014 were identified for:

• Regulation 12 Safe care and treatment

• Regulation 17 Good governance

Summary of this inspection

• Regulation 10 Dignity and respect

The Care Quality Commission placed urgent conditions on the location's registration and also issued a warning notice and requirement notices. The Care Quality Commission placed the location in special measures on 20 May 2019. The provider sent the Care Quality Commission their action plans outlining how they would address the breaches of regulations. They closed Flower Adams wards and the Care Quality Commission removed the conditions.

At this inspection we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for Regulation 12 safe care and treatment and two breaches under Regulation 17 good governance.

Our inspection team

The team that inspected the service comprised of two Care Quality Commission inspectors and two inspection managers.

Why we carried out this inspection

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

However, the Care Quality Commission continued its enhanced monitoring and assessment of information from the provider and others.

This was an unannounced focused inspection. We carried out this inspection as we received information of concern from the provider and others relating to safeguarding patients and the reporting, investigation and management of incidents.

How we carried out this inspection

We carried out this inspection using a mixture of on site and remote inspection activity over six days. We visited the hospital site on two days. We carried out interviews with staff and patients remotely via telephone/video conference. We also looked at a number of patient records and incidents remotely as well as on site.

As this was a focused inspection, we have reported our findings under safe, caring and well-led domains. We did not inspect all key lines of enquiry.

During the inspection visit, the inspection team:

- requested and viewed 79% of all available closed circuit television linked to restraints across all wards, between 19 July and 18 August 2020;
- looked at records staff completed for incidents (for the sample of footage seen);
- reviewed and tracked 11 incident reports from May 2020 to August 2020;
- looked at six patient observation records;
- spoke with eight patients;
- spoke with the hospital manager, clinical manager, quality and compliance manager, safeguarding administrator, housekeepers and advocacy staff;
- looked at five patients' care and treatment records across all wards;
- looked at 38 records managers completed when recruiting staff to work at the hospital, along with other human resources records;
- looked at 13 records managers kept of agency staff working at the hospital;

Summary of this inspection

- looked at 16 records managers completed when supervising staff;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with eight patients across all wards and the three core services. Patients told us staff treated them with kindness and respect.

Patients told us they felt safe and staff were available when they needed them. However, one patient said that staff did not offer them individual keyworker time and he knows from previous experience of having this, that it would benefit himself and other patients.

Patients told us they had access to activities and psychological therapies on the wards including; cooking, music, exercise, puzzles and group therapies.

Patients told us they attend their care and treatment review meetings.

Three patients told us they have not seen their care plan. One patient told us he was not clear about what was happening as staff were not explaining things to him.

Patients told us they knew how to raise a concern or make a complaint. However, one patient said the official process is not clear and there is misleading information on the ward notice board about how to make a complaint.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not rate the service at this focused inspection.

- Staff did not always follow the provider's Covid-19 policy or infection prevention and control guidelines set out by the government. Staff did not always wear face masks, some staff wore them inappropriately and did not always dispose of them correctly. This posed a risk that patients, staff or others could transfer infection.
- Managers had not assured themselves that staff practice during restraint was appropriate. We were not assured that managers completed a sufficient number of closed circuit television reviews to evidence staff safely restrained patients.
- Patient Covid-19 risk assessments were not individualised, or person centred. Not all risk assessments took into account patients' medical conditions where appropriate.
- Although managers we spoke with knew how to raise a safeguarding referral and the process to follow, we found one example where the provider had not correctly reported an incident as a safeguarding concern within the hospital. On further conversations with the provider we were not fully assured the provider had taken concerns raised by the patient seriously and had taken the view this was a repeat of previous allegations. Staff had not fully updated the patient's care plan to reflect the incident.

However:

- Staff had completed and kept up-to-date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. Staff received training on how to recognise and report abuse, appropriate for their role.
- Staff used restraint techniques effectively and manage most incidents well.
- Managers told us staff and patients were debriefed and supported after any serious incident. Three out of four patients told us they received a debrief after being involved in an incident.
- Managers shared learning from serious incidents with their staff, both internal and external to the service.

Summary of this inspection

Are services effective?

This was a focused inspection to specifically check on the areas of concern we had received. We did not inspect this key question.

Are services caring?

- Staff treated patients with kindness and respect. Staff were available when patients needed them.
- Patients had access to activities and psychological therapies on the wards.
- Patients knew how to raise a concern or make a complaint.
- Advocacy services visited all wards and saw patients regularly.

However:

- Patients were not always shown or given a copy of their care plans.

Are services responsive?

This was a focused inspection to specifically check on the areas of concern we had received. We did not inspect this key question.

Are services well-led?

- Managers failed to monitor staff wearing face masks appropriately and failed to take appropriate action when staff breached infection prevention control guidance. We also found that managers failed to monitor the appropriate disposal of clinical waste in some areas.
- Managers had not taken every step to ensure they recruited staff that had the right skills, experience and values to work with a vulnerable patient group. Of a sample of 38 staff employment records we looked at, 25 (66%) did not follow the provider's recruitment, selection and appointment of staff policy. Examples included; where managers had not recorded all answers to interview questions, had not sought appropriate employment references, had not used the provider's scoring system, interviews were only carried out with one interviewer and employment records did not contain interview notes.
- The providers guidance on the volume of closed circuit television to review was unclear. We were not assured that managers completed a sufficient number of closed circuit television reviews to evidence staff safely restrained patients.
- Managers were not consistent in the paperwork stored on file for agency workers.

However:

- Managers supported staff through regular, constructive managerial, clinical and safeguarding supervision of their work.

Detailed findings from this inspection

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

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

This was a focused inspection. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service to avoid repetition.

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

(for example, treatment is effective)

This was a focused inspection to specifically check on the areas of concern we had received. We did not inspect this key question.

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

This was a focused inspection. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service to avoid repetition.

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

(for example, to feedback?)

This was a focused inspection to specifically check on the areas of concern we had received. We did not inspect this key question.

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

This was a focused inspection. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service to avoid repetition.

Long stay or rehabilitation mental health wards for working age adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Safe and clean environment

Staff did not always follow the provider's Covid-19 policy or infection prevention and control guidelines set out by the government. The Care Quality Commission had received anonymous concerns that staff did not always wear their masks. We verified this at our visit on 19 August 2020. This posed a risk that patients, staff or others could transfer infection. We viewed staff on closed circuit television not wearing face masks or wearing masks inappropriately under their nose or below their chin. We also saw staff on day one of our site visit to the hospital not wearing face masks or wearing face masks inappropriately. The provider's Covid-19 policy dated July 2020 states, "company policy is that face masks must be worn in all of Cygnet's services across England, Wales and Scotland - hospitals and residential/social care settings alike. This is applicable to all staff in these services." We raised this with the provider who took action to address the matter. When we returned for day two of our site visit, we saw staff wearing face masks appropriately.

We saw, on day one of our visit to the hospital, discarded face masks in public areas outside the hospital, including hanging from trees, on the ground and in an outside bin not specifically designed for the disposal of clinical waste. However, when we returned for day two of our site visit, we did not find this, and the provider told us they had cleared the masks from the area.

Safe staffing

We reviewed 31 days of staffing figures taken from the morning meeting minutes across all wards. We found 10 out of 31 days had less support staff than planned. We found 14 out of 31 nights had less support staff than planned. However, the provider sent us additional information after we completed the inspection which shows there were five unfilled shifts during the 31 days we looked at on site. We were not provided evidence of how the provider filled these shifts after the morning meeting.

All days and nights had the planned number of registered nurses per shift.

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

The compliance for mandatory and statutory training courses at 19 August 2020 was 91%. Of the training courses listed, two failed to achieve the provider's target. The provider set a target of 90% for completion of mandatory and statutory training.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

The provider completed a Covid-19 risk assessment for all visitors and staff when they arrived on site, this included visitor and patient temperature checks when they arrived.

We reviewed the provider's system for checking closed circuit television to review staff restraints on patients to check that staff used appropriate techniques that were not abusive. We reviewed 79% of all available closed circuit television linked to restraints across all wards, between 19 July and 18 August 2020. We reviewed 100% of available closed circuit television footage linked to patient restraints for Larch court and Ramsay ward, 88% for Highwoods ward

and 28% for Oak court. Closed circuit television for Highwoods ward was not available until after 11 August due to technical issues on the ward which the provider notified us about and had taken action to resolve.

Staff did not accurately record the time incidents happened on Oak court. We looked at five episodes of closed circuit television footage linked to reported incidents. In four examples the time recorded by staff on the record was between 35 and 90 minutes outside of the time on the footage. In the fifth example the incident described by staff could not be located on the provider's closed circuit television footage, despite the fact we looked for 90 minutes past the recorded time. This meant the provider would have difficulties reviewing closed circuit television footage as part of their incident investigation and assurance.

Staff were observed to use restraint techniques effectively and manage most incidents well.

We reviewed one incident of restraint where we had a number of concerns including the recording of the restraint and how staff managed the privacy, dignity and safety of the patient involved. However, these concerns had been identified by the hospital via their internal audit process and managers had raised a safeguarding alert with the local authority and notified the Care Quality Commission.

Between 19 July and 18 August 2020 managers reviewed 11% (4 out of 35) of restraint incidents which occurred in areas covered by closed circuit television. We expanded the time period and reviewed the 'MAPA incident CCTV review form' which recorded closed circuit television reviews completed between April 2020 and 18 August 2020. Managers reviewed an average of six episodes of restraint captured on closed circuit television per month. This equated to 1.5 episodes per ward. We were not assured the hospital had undertaken enough reviews of available closed circuit television to make a judgement about staff practise. We were told the hospital intended to undertake a review of all available incidents for August 2020, but we were not supplied with this evidence.

We were not assured that the provider's documentation for recording closed circuit television reviews were comprehensive. The flow chart within appendix one of the document states that 'any findings that do not meet the standards must be immediately referred to the safeguarding lead and escalated to clinical manager/ hospital manager'. Staff did not record outcomes, or the further actions required following their closed circuit television reviews on the provider's restraint assurance tracker. Where reviewing staff had identified issues, they had not documented what had been done with this information or if it had been followed up. The provider's restraint assurance tracker did not detail whether staff had reviewed the full incident on closed circuit television. The document did not detail the reviewing staff's details. However, the provider had a system in place for staff to check daily that closed circuit television was operating and recording correctly. We viewed the closed circuit television and electronic monitoring daily checklist for August 2020 which was complete for all wards.

Patient risk assessments were not always individualised, or person centred. Staff completed risk assessments for all patients. We reviewed five patient care records and found staff had completed Covid-19 risk assessments for all patients. However, these risk assessments were very similar and not individualised for patients taking into account their current physical health conditions where appropriate. We found one patient had a physical health care plan regarding asthma, but staff had not identified within their Covid-19 risk assessment as at 'moderate' risk in the 'clinically vulnerable' risk category (as defined by the NHS). We were not assured staff would know what additional support and supervision to give this patient and keep them safe from Covid-19.

We also viewed five patients' daily risk assessments which ward managers referred to at morning multidisciplinary meetings to identify risks for the ward each day. We found in some instances that staff had cut and pasted entries from one day to another and did not give clear details for the rating. This was an issue we had previously reported on in our comprehensive November 2019 inspection and which the provider sent us an action plan outlining their actions to address the issue.

Staff had not clearly documented patient observation levels on the recording paperwork. We reviewed six observation records for four patients. We found that patient observation levels had been recorded differently from day to night and did not match the patient's care plan. However, staff were observing patients according to their care plans and prescribed observation level.

Safeguarding

Long stay or rehabilitation mental health wards for working age adults

We received corporate whistleblowing concerns relating to the provider's three locations in Essex. Concerns related to the providers safeguarding processes and incident reporting. The provider told us they had commissioned an external body to carry out an investigation into these whistleblowing concerns.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. This was an improvement since our previous focussed inspection in March 2020.

Managers we spoke with knew how to report a safeguarding referral and the process to follow. However, we found one example where staff had not reported an allegation of abuse of a patient appropriately. On further conversations with the provider we were not fully assured the provider had taken concerns raised by the patient seriously and had taken the view this was a repeat of previous allegations. We found there was a significant delay (20 days) in it being reported as a safeguarding concern and investigated and the provider did not send the Care Quality Commission a statutory notification until prompted by us. The Care Quality Commission also had concerns about the thoroughness of the provider's initial investigation.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Reporting incidents and learning from when things go wrong

Staff did not report one serious incident clearly and in line with the providers policy. However, there was an improvement in the level of detail within the reports since our previous inspection.

Managers told us staff and patients were offered debriefs and supported after any incident. Three out of four patients told us they received a debrief after being involved in an incident. This was an improvement since our previous focussed inspection in March 2020.

Managers shared learning from serious incidents with their staff, both internal and external to the service.

Managers told us learning from incidents was discussed with staff in monthly team meetings and staff looked at improvements to patient care. We also saw evidence of this being discussed within staff supervisions.

Managers discussed incidents in morning multidisciplinary meetings. We reviewed 10 recorded incidents against the daily morning meeting minutes to check they were being discussed the following day as per the provider's protocol. We found 80% of the incidents we reviewed were discussed in the provider's daily morning meeting.

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

(for example, treatment is effective)

This was a focused inspection to specifically check on the areas of concern we had received. We did not inspect this key question.

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

Kindness, privacy, dignity, respect, compassion and support

We spoke with eight patients across the wards and three core services. All patients said staff treated them with kindness and respect. All patients said they felt safe and staff were available when they needed them. However, one patient said they didn't get offered one to one time with staff and they knew from previous experience of having this, that it would benefit them and other patients.

Patients told us they had access to activities and psychological therapies on the wards including; cooking, music, exercise, puzzles and group therapies.

Long stay or rehabilitation mental health wards for working age adults

Involvement in care

Patients were not always shown or given a copy of their care plans. Patients told us they attended their review meetings. Staff told us they discussed patient care plans at these review meetings. However, three patients told us they have not seen their care plan. One patient told us they were not clear about what was happening as staff were not explaining things to them.

Patients told us they knew how to raise a concern or make a complaint. However, one patient said the official process was not clear and there was misleading information about how to do this on the ward notice board.

Advocacy services visited all wards and saw patients regularly.

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

This was a focused inspection to specifically check on the areas of concern we had received. We did not inspect this key question.

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

Leadership

There had been a recent change in management of this hospital. The previous hospital manager deregistered in July 2020. The provider recruited another hospital manager who is also the regional director across the provider's three locations in Essex. There had also been a change in safeguarding management and safeguarding leads, but the hospital manager was now supported by a safeguarding administrator.

Governance

The provider's protocol for restraint incident closed circuit television assurance reviews was not clear, comprehensive and we were not assured it could give the provider assurances that staff practice during a restraint was appropriate. We reviewed the protocol and found the document did not state how many reviews, or percentage of reported incidents should be reviewed as part of this assurance process. We found that staff had only audited five out of 63 (8%) incidents where physical restraint had been required from 19 July 2020 to 18 August 2020 via a closed circuit television review. However, only four of these were captured on the provider's closed circuit television. Therefore, the provider had only reviewed four restraint incidents via their restraint incident closed circuit television assurance reviews, which represented 6% of all restraint incidents for this period. This was despite lessons learnt from a review of closed circuit television at other provider locations managed by the same hospital manager. This was an issue we had previously reported on at our comprehensive November 2019 inspection and which the provider sent us an action plan outlining their actions to address the issue.

Managers had not taken every step to ensure they recruited staff that had the right skills, experience and values to work with a vulnerable patient group. Of a sample of 38 staff employment records we looked at, 25 (66%) did not follow the provider's recruitment, selection and appointment of staff policy. We found interviewers had not used the provider's scoring system for 13 out of 38 (34%) staff interviews. We found in 11 out of 38 (29%) staff interviews, that interviewers had not documented answers for between one and 14 questions. We found multiple interview question templates ranging from 17 to 20 questions in length, which the provider had developed for interviewers to assess candidate's suitability for the role. This meant that in some interviews staff were not asked over half of the questions in the interview template. We found seven out of 38 (18%) interviews were carried out with only one interviewer whereas the provider's standard is there should be a minimum of two interviewers. We found three out of 38 (8%) employment records we viewed did not contain interview notes. The provider's recruitment, selection and appointment of staff policy states that, "interviews should be undertaken by a minimum of two people who have the skills required to undertake the process. All interview records should be signed, scored and dated. Each interviewer must complete their own interview assessment paperwork."

Managers were not consistent in how they stored paperwork in files for agency workers. We reviewed 13 agency files. We found seven out of 13 (54%) did not have any staff references on file and three out of 13 (23%) only

contained one reference. However, nursing agencies are responsible for carrying out employability checks on their staff, the provider is responsible for keeping a record of these checks for the staff that work on their site. The provider's risk assessment for the nursing agency stated, "two references must be given according to the two last worked positions."

Management of risk, issues and performance

Managers did not full ensure they consistently implemented or monitored adherence to the provider's Covid-19 policy or government guidelines to ensure staff wore face masks in the hospital to reduce the risk of transmission of Covid-19. We found that managers failed to comply with infection prevention control monitoring of staff wearing face masks appropriately and adhere to the provider's Covid-19 policy and take appropriate action when observing staff not wearing face masks or wearing them inappropriately. The provider's Covid-19 policy states, "company policy is that face masks must be worn in all of Cygnet's services across England, Wales and Scotland - hospitals and residential/social care settings alike. This is applicable to all staff in these services." The provider's policy also states that, "should an employee refuse to wear a face mask, the matter may be deemed a disciplinary issue." We also found that managers failed to monitor the appropriate disposal of clinical waste in some areas.

Managers supported staff through regular, constructive managerial, clinical and safeguarding supervision of their work. This was an improvement since our previous comprehensive inspection in November 2019.

We checked the providers systems for assessing the suitability and competency of agency staff following shared intelligence from another of the provider's locations. The provider had a risk assessment in place for this nursing agency. However, it stated there was no current risk with the agency staff and it did not detail the intelligence given from the other location. We spoke to the hospital manager further who said they had spoken to ward managers and they had no concerns about the competency of agency staff provided at their hospital and therefore they had staff working on their wards. However, since our previous comprehensive inspection in November 2019, the provider had notified us of two incidents involving agency staff from this nursing agency resulting in the agency staff no longer working at the provider due to conduct and competency issues.

Wards for people with learning disabilities or autism

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are wards for people with learning disabilities or autism safe?

This was a focused inspection. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service to avoid repetition.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

This was a focused inspection to specifically check on the areas of concern we had received. We did not inspect this key question.

Are wards for people with learning disabilities or autism caring?

This was a focused inspection. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service to avoid repetition.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

This was a focused inspection to specifically check on the areas of concern we had received. We did not inspect this key question.

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

This was a focused inspection. We have reported our findings for all three core services under the long stay rehabilitation mental health wards for working age adults core service to avoid repetition.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

We told the provider that it must take action to bring services into line with two legal requirements. This action related to all three core services.

- The provider must ensure they follow their Covid-19 policy and infection prevention and control guidelines set out by the government (Regulation 12 (1)(2)(h))
- The provider must ensure they dispose of clinical waste appropriately (Regulation 12 (1)(2)(h))
- The provider must ensure managers take appropriate action when observing staff not following their Covid-19 policy or infection prevention and control guidelines set out by the government (Regulation 17 (2)(a)(b))
- The provider must ensure they follow their recruitment, selection and appointment of staff policy (Regulation 17 (2)(a)(b))

Action the provider SHOULD take to improve

We told the provider that it should take action either 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 accurately record the time of incidents on their incident recording system to coincide with the time of the incident according to their closed circuit television.
- The provider should ensure staff maintain the privacy and dignity of patients during all incidents, including restraints.
- The provider should review their processes for staff review of closed circuit television of staff restraints on patients, to ensure meaningful sampling.
- The provider should ensure their recording of closed circuit television reviews is comprehensive.
- The provider should ensure patients Covid-19 risk assessments are individualised and person centred taking into account their current physical health conditions where appropriate.
- The provider should record all safeguarding incidents to the appropriate external bodies timely and without delay.
- The provider should ensure patients get one to one time with their named nurse.
- The provider should ensure patients are shown, given a copy and understand their care plans.
- The provider should ensure the paperwork held on file for agency workers is consistent.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance