Cygnet Hospital Maidstone

Quality Report

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

Ratings

Overall rating for this location

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

Overall summary

We carried out a focused inspection in response to concerns shared with us from members of the public, external agencies and intelligence held by the CQC. Concerns included: patient safety; patient risk and management of risk; high use of observation levels; the number of incidents on the ward; staffing levels; high use of agency staff; staff training; and culture and morale on the ward. The concerns were specific to Roseacre ward and we therefore only inspected this ward.

We did not re-rate the service following this inspection. The ratings from the comprehensive inspection on 19 and 20 March 2019 stay the same. The service was rated good overall. However, a requirement notice was issued for breach of Regulation 12, safe care and treatment. This was specific to Bearstead ward only. The inspection found patients' risk assessments were not always completed and did not mitigate risks, and action taken to respond to incidents on the ward was not always appropriate.

During this focused inspection we inspected the safe, effective and well-led questions for Roseacre ward and we found:

- The recording of risk information was variable and inconsistent. Patients risk assessments were not always updated following an incident or reflective of all risks identified during assessment or following an incident. The governance processes and audits for monitoring the quality of patients' individual risk assessment records was not always effective.

Summary of findings

- Staff did not always report incidents on time. Some incident forms were completed sometime after the incident happened and the senior clinical team were not aware of those incidents until a later date. Incidents forms were not always fully completed and lacked some information which was needed. The process for monitoring and responding to reports of incidents submitted late and not in line with their policy was not effective.

  However:

- Ward staff, senior managers and patients on Roseacre ward told us that the last few months prior to the inspection had been challenging on the ward but they felt things had improved a lot recently. Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution. Patients told us they felt safe on the ward and were happier now the ward had settled down and less agency staff were on duty.

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for all new staff.

- The service managed all reported patient safety incidents well. Staff recognised incidents. Managers investigated all reported incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.

Summary of findings

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Cygnet Hospital Maidstone

Services we looked at:
Acute wards for adults of working age and psychiatric intensive care units.

Summary of this inspection

Background to Cygnet Hospital Maidstone

Cygnet Hospital Maidstone is a new, purpose built, 65-bed mental health facility for adults. The hospital has four wards:

• Roseacre ward is a 16-bed specialised personality disorder ward for women (acute wards for adults of working age and PICU)

• Kingswood ward is a 16-bed high dependency rehabilitation ward for men (long stay/rehabilitation wards for working age adults)

• Bearstead ward is a 17-bed, however, only 15 beds are ever used, psychiatric intensive care service for men (acute wards for adults of working age and PICU)

• Saltwood ward is a 16-bed forensic low secure ward for men (forensic/inpatient secure wards).

Cygnet Hospital Maidstone was registered with the Care Quality Commission (CQC) on 5 October 2018 to provide assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury. At the time of our inspection, the service had a registered manager and nominated individual, as per CQC's requirements.

We first inspected Cygnet Hospital Maidstone on 19 and 20 March 2019. The service was rated 'good' overall. However, a requirement notice was issued for a breach of Regulation 12, Safe care and treatment. This was specific to Bearstead ward and was because patients' risk assessments were not always completed and did not mitigate risks; and action taken to respond to incidents on the ward was not always appropriate.

Our inspection team

The team that inspected the service comprised one CQC inspection manager, two CQC inspectors; one nurse specialist advisor and an expert by experience.

Why we carried out this inspection

We carried out a focused inspection in response to concerns shared with us from members of the public, external agencies and intelligence held by the CQC. Concerns were specific to Roseacre ward and included: patient safety; patient risk and management of risk; high use of observation levels; the number of incidents on the ward; staffing levels; high use of agency staff; training; and culture and morale on the ward.

As this was not a comprehensive inspection, we did not pursue all our key lines of enquiry. Therefore, this report does not show an overall judgement or rating of the service and the previous ratings remain the same. Our resources were focused on inspecting the current areas of alleged concern and this should be considered when reading this report.

How we carried out this inspection

We have reported specifically on the areas of alleged concern which fell into the key questions of safe, effective and well-led. Therefore, our report does not include all of the headings and information usually found in a comprehensive report.

Before the inspection visit, we reviewed information that we held about the service.

During the inspection visit, the inspection team:

Summary of this inspection

- visited Roseacre ward, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with the registered manager for the service and the ward manager and team leaders for Roseacre ward
- spoke with 11 other staff members; including the doctor, nurses, occupational therapist and assistant, psychologist and support workers
- attended and observed two shift-to-shift hand-over meetings, a ward multidisciplinary team meeting, a daily flash meeting and a therapy session
- looked at eight care and treatment records of patients
- looked at 12 incident forms
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with six patients on the ward who all gave positive and negative views. They all told us they felt safe on the ward. They said there were always enough staff but for a period, most of the staff had been agency staff and they did not always know how the ward worked. However, they had not noticed as many agency staff on the ward in recent weeks. Patients mostly spoke very positively about the staff and said they were kind, caring and supportive of their needs. They said if they needed anything staff would always try and help them.

Patients told us they felt the ward was still too restrictive following some incidents that happened on the ward. The doors to the enclosed courtyard garden were always locked and they had to ask staff if they wanted to go outside. They also said the remote control to the communal lounge television was kept in the office due to some patients swallowing batteries.

All the patients spoke about how the ward had felt very unsettled over the last few months. They said this was because two patients had caused repeated incidents on the ward which had taken up most of the staff's time. They spent a lot of time in their bedrooms, so they could keep away from the incidents. Since the two patients had moved to another service, they said the ward had become much calmer and everyone seemed happier. They said people were back socialising in the communal areas and not staying in their bedrooms all the time.

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 reviewed eight patients' records and found risk assessments, risk management and care plans were not always updated following an incident or reflective of all risks identified.
- Staff did not always report incidents on time. Incidents forms were not always fully completed and lacked some information which was needed.

However;

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- The ward had a good track record on safety. When reported, the service managed patient safety incidents well. Staff recognised incidents. Managers investigated all reported incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in the care they received. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Are services well-led?

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.

Summary of this inspection

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

However:

- The audit checks on patient risk assessments carried out by the provider had not identified the concerns we found during the inspection.

Detailed findings from this inspection

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

Safe	
Effective	
Well-led	

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

Safe staffing

The service had enough nursing and support staff to keep patients safe. In November 2018, the ward had seven registered nurse and 10 healthcare assistant vacancies. At the time of our inspection, the ward had no vacancies.

The ward had reducing rates of bank and agency staff. Over the past 12 months agency use peaked at 46% of shifts in a month. However, for the week prior to our inspection, agency use was 20% of shifts. We were told the main reasons for bank and agency usage for the ward was vacancies and level of observations to support patients. There was a clear correlation between a reduction in agency staff use and a reduction in the number of vacancies for the ward.

Managers limited their use of bank and agency staff and requested staff familiar with the service and ward. Agency nurses were selected to work on block contracts where possible.

The ward manager could adjust staffing levels according to the needs of the patients. We saw that extra staff had been used during a period when there was an increase in the clinical need of the patient group.

Roseacre ward had enough staff on each shift to carry out any physical interventions safely.

All staff received an induction. Induction packages were available for clinical staff, non-clinical staff, bank staff, students and agency staff. Induction provided staff with information on organisational policies and procedures and gave them the opportunity to work supernumerary to ward staffing numbers. However, prior to this inspection, concerns were shared with us about the ward specific orientation and induction. This included unfamiliar staff not receiving a comprehensive induction due to the ward being very busy and lack of availability of existing staff to show them what to do. We shared these concerns with the registered manager who told us that since our inspection in March 2019, the service had changed the way they ran their staff induction programme. For a few months prior to this inspection, they had introduced a ward-based induction programme for unfamiliar staff. However, the service had recognised the induction programme had not worked as well and told us the action they were taking to make improvements and support staff.

Assessing and managing risk to patients and staff

We reviewed eight care records, including risk assessments and risk management plans and corresponding care plans.

Staff did not always record risks to clients. We looked at eight patients care records and found risk assessments were not always updated following a change in risk or after an incident. They were not always reflective of risks identified during the patient's comprehensive assessment. However, staff we spoke with were very aware of the risks and safeguarding concerns for the patients on the ward and told us what action was being taken to support the patients. Records did not reflect what staff knew and the action they had taken. Risks information was shared and discussed as part of the wider multidisciplinary team and appropriate action and support taken.

Staff used recognised tools to assess the patients' risks. These included the short-term assessment of risk and treatability (START) and the historical clinical risk management 20 (HCR20) which was completed with input from the ward psychologist. Both were appropriate for the patient group being treated on the ward.

Reporting incidents and learning from when things go wrong

The management of patient safety incidents was variable. Staff recognised the majority of incidents and reported them appropriately. However, there were delays in the

reporting of some incidents and some incident reports were incomplete. We reviewed 12 incident forms and found three examples of incidents being reported in retrospect, one incident was not reported for 17 days.

Staff did not always raise concerns and report incidents and near misses in line with the provider's policy. During the morning handover on the day of the inspection a staff member disclosed a number of incidents that had occurred the day before but these had not been reported as incidents at the time.

Staff knew how to raise an incident, although there were some concerns around the process used. A paper incident reporting book was used. However, during the inspection we found two incident reporting books being used at the same time. Staff did not always record the incident report number in the care records of patients which made tracking of incidents difficult.

Incident report forms were not always completed fully. We found examples where no risk rating had been completed, or where the risk rating did not match the level of risk presented. An incident which resulted in a serious injury for the patient was rated as moderate risk. The action plans were often poor, stating "MDT to review" or "care plan to be updated" without detailing how the care plan would change as a result of the incident.

The duty of candour regulation explains the need for providers to act in an open and transparent way with people who use services. It sets out specific requirements that providers must adhere to when things go wrong with people receiving care and treatment. The provider had a duty of candour policy in place. Staff we spoke with understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff after any serious incident.

Staff received feedback from investigation of incidents, both internal and external to the service. The hospital director sent a monthly quality newsletter to all staff which identified key learning from incidents across the hospital. Managers also discussed feedback from investigations with staff during handovers, staff meetings and in supervision.

There was evidence that changes had been made because of feedback. Following a serious incident on the ward, the service was in the process of changing the location of and type of sharp's bin used.

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

(for example, treatment is effective)

Skilled staff to deliver care

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Training rates were 100%. Senior managers had good oversight of staff training levels.

Non-medical staff received regular, constructive clinical supervision of their work. Clinical supervision rates were 80% at the time of inspection.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Important information was displayed in the nursing office on the ward.

Managers made sure staff received specialist training for their role. Five members of staff had completed a full 10-day training course in dialectical behaviour therapy, so they could deliver therapy sessions to patients. Dialectical behaviour therapy is a talking therapy specifically designed for patients with a diagnosis of personality disorder. All other staff were trained or being trained so they could help facilitate the sessions and support patients to use their dialectical behaviour therapy skills in everyday life. We observed a therapy session and found staff to be very respectful and encouraging towards the patients. Patients appeared engaged and relaxed. They told us the group sessions were really helpful. However, patients we spoke with told us some of the staff were much better than others at supporting them on the ward with their dialectical therapy skills as they had more knowledge of the therapy. Some staff we spoke to also confirmed this was the case. At the time of the inspection, the service had not yet reviewed the impact of dialectical behaviour therapy on the ward, staff competency or feedback from patients.

Multi-disciplinary and inter-agency team work

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

In addition to qualified nurses and nursing assistants, the ward had a multidisciplinary team. This included a consultant psychiatrist, a middle grade doctor, social worker, an occupational therapist, an occupational therapy assistant a psychologist and a psychology assistant. Each contributed to the delivery of care and treatment to patients.

There were regular face-to-face multidisciplinary team meetings, with professionals, patients and families invited to attend or contribute before the meeting. In addition to one-to-one work with the patients, the psychology team supported staff and patients with reflective practice sessions and de-brief sessions following incidents.

We observed two shift-to-shift handovers and a multidisciplinary team meeting on the ward. They were structured, and discussions included background history of the patient, assessment of current presentation, patient, risk information, medicine changes, leave from the ward and discharge planning. However, the white board which was used to record some key pieces of information, was not always kept up to date.

Staff worked with health, social care and other agencies to plan integrated and coordinated pathways of care to meet the needs of people using the service. We saw referrals and signposting to other supporting services, including primary healthcare services.

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

Leadership

Since our last inspection in March 2019, there had been some changes to the ward management, including a change of ward manager and some of the team leaders.

Culture

The culture on Rosecare ward was good and an improving picture. At the time of our last inspection, we found the culture to be exceptional with high levels of engagement between staff and patients. However, this had changed. Staff we spoke with said the last few months had been particularly challenging due to the level of incidents on the ward and the acuity of some of the patients. This had affected everyone on the ward and meant that some things were not always done as well as they hoped for. Staff said in the weeks prior to this inspection, things had improved. They were happy in their jobs, motivated to attend work every day and proud of the service they offered. They reported minimal work-related stress and felt the service had supported their health and wellbeing. They were excited to drive improvements on the ward and better the lives of the patients.

There was a good working relationship between members of the multidisciplinary team. Discussions observed between colleagues were respectful and supportive in nature.

Staff told us the service was continuously open to change and improvement. Staff felt their ideas for changes to service delivery were listened to and felt encouraged and empowered to make suggestions.

Staff told us they felt confident whistleblowing and raising concerns to any senior manager within the organisation. Staff felt able to do so without fear of repercussions and that they would be taken seriously.

The service promoted equality and diversity. They had a multi-cultural team which reflected the diversity of the local community and patient group.

Governance

The service used key performance indicators to monitor service performance and productivity.

The provider had a clear governance structure to ensure the safe and effective running of the service. The governance systems ensured a comprehensive review of incidents was completed within set timeframes and to help prevent future occurrence. Managers met regularly in governance meetings. The registered manager chaired the monthly hospital wide governance meetings. Ward managers chaired the ward level governance meetings which were also held monthly. All governance and risk assurance procedures were structured with data readily available. However, checks about the recording of patient risk were not always effective as the managers were not aware that risk assessments and risk management plans were not always kept up to date.

Policies and procedures were regularly reviewed to make sure they were relevant and in line with national guidance. Staff had easy access to all policies and procedures and were kept updated when changes were made.

Managers and staff completed audits. The service had an agreed, planned schedule of clinical and non-clinical audits. This included regular audits on medicines management, seclusion and long-term segregation, infection control and the Mental Health Act. We saw that audit findings were discussed which led to practice changes and improvements where needed.

The service used a performance dashboard to monitor and improve key aspects of care and treatment. The dashboard rag rated (system based on traffic lights using red, amber and green to highlight different ratings and indicate what was working well or needed improvement) key aspects of performance including the amount of therapeutic activity, key documentation, numbers of restraints and seclusions, admissions and discharges and staffing. Ward managers were familiar with the dashboard and said they used the findings to improve the quality of care on their respective wards.

We observed the daily flash meeting where information from each ward was discussed including staffing numbers, admissions and discharges and any incidents within the last 24 hours. Each ward was represented by the ward manager, team leader or nurse who provided a handover summary to the rest of the senior multidisciplinary team. Discussions between staff were respectful and supportive. A spreadsheet was updated daily to capture all the information and ensure, where needed, actions were taken. However, the incidents that were reported late, were added to the spreadsheet retrospectively also and not highlighted to show they had been received late. This meant although the service were aware some incidents were not being reported as soon as they should be, they were not tracking or monitoring the late reporting.

Management of risk, issues and performance

There was clear quality assurance management and performance frameworks which were integrated across all policies and procedures. The service worked closely with the provider's quality and assurance team to ensure consistency across the staff and service.

The learning from complaints, incidents and patient feedback was identified and actions were planned to improve the service. Staff and patients were involved in post incident de-briefs and review processes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure they improve information recorded in patients' risk assessments, risk management and care plans. Risk assessments and risk management plans should be updated following a change in risk and reflective of all risks identified. (Regulation 12)

Action the provider SHOULD take to improve

- The provider should ensure incident reports are completed at the time of the incident and incident reports are detailed with all relevant information recorded.
- The provider should ensure their governance processes and audits for monitoring the quality of patients' individual risk assessment records is effective.
- The provider should ensure they have an effective process for monitoring and responding to reports of incidents that are submitted late and not in line with their policy.

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 **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** **The provider had not ensured records relating to patients' individual risk assessments and corresponding care plans were updated following a change in risk, or reflective of all risks identified.** **This was a breach of regulation 12 (2) (a)**