Cygnet Hospital Sheffield

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

We carried out an unannounced focussed inspection on 11 and 12 September 2017 at Cygnet Hospital Sheffield on the general adolescent ward called Peak View, following two significant incidents which had taken place. We identified concerns which we fed back to the management team at the time of our inspection.
This inspection took place subsequent to the comprehensive inspection of August 2017 where we rated the hospital as requires improvement. This inspection was not rated.

During the inspection we found:

- There were shortfalls to the processes for individual patient risk assessment. Records and care plans did not always incorporate known risks relating to patients.
- Staff did not review care plans and risk assessments appropriately in response to incidents. Staff did not routinely update information which meant the care and treatment they provided did not always reflect what was documented. We could not be assured that patients were therefore receiving appropriate care in instances where their information was not correct.
- Documentation was incomplete in some instances and stored in the wrong records. Some information was difficult to navigate.
- Staff did not always record and review periods of patient leave consistently.

However:

- Two of the three patients we spoke with said the care was good and they felt safe.

Summary of findings

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Background to Cygnet Hospital Sheffield

Cygnet Hospital Sheffield is an independent mental health hospital that provides low secure and locked rehabilitation services for women; and child and adolescent mental health services for male and female adolescents aged between 11 and 18. The hospital has capacity to provide care for 55 patients across four wards. These are:

• Spencer: 15 bed low secure ward for female patients

• Shepherd: 13 bed long stay rehabilitation ward for female patients

• Peak View: 15 bed mixed gender acute ward for children and adolescents

• Haven ward: 12 bed mixed gender psychiatric intensive care unit for children and adolescents.

The hospital is registered to provide the regulated activities of: treatment of disease, disorder or injury; assessment or medical treatment for persons detained under the 1983 Mental Health Act and diagnostic and screening procedures.

At the time of this inspection, the registered manager was not working at the hospital but had not yet de-registered. The registered manager is responsible for managing the regulated activities at the service. A new hospital manager had commenced employment two weeks before the inspection. The manager told us they would be submitting an application with the Care Quality Commission for registration as manager of the service.

Our inspection team

The inspection team was led by Care Quality Commission inspector, Anita Adams.

Including the team leader, the inspection team consisted of two Care Quality Commission inspectors, one inspection manager and one head of hospital inspections.

Why we carried out this inspection

The inspection commenced on 11 September 2017 and was unannounced. It took place over two days and was focussed on the general adolescent ward, Peak View.

The inspection was prompted in part by notifications of two incidents whereby two patients on Peak View were exposed to risk of harm. The information shared with the Care Quality Commission indicated potential concerns about the management of patients leave arrangements and staff's awareness and management of patient risks. This inspection examined those areas. We also took into account any other areas of concern we identified whilst we were present at the service.

The inspection was focussed on specific aspects of the service in relation to the key questions of 'is the service safe'. We did not rate this inspection.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Summary of this inspection

Is it well-led?

During this inspection, we focused only on relevant issues that had led us to undertake the focussed inspection. These were relevant to the key questions of is the service safe. Before the inspection, we reviewed information that we held about the hospital where this was pertinent to the general adolescent ward, Peak View.

This inspection was unannounced which meant no one at the service knew we would be attending. At the time of our inspection there were 10 patients on Peak View. During the inspection visit, the inspection team:

- visited Peak View during the day time one day, and late afternoon and evening the next day
- spoke with the ward manager
- spoke with seven members of staff including a consultant psychiatrist, nurses and support workers which included a mixture of permanent and agency staff
- attended and observed a patient community meeting
- attended and observed a multidisciplinary meeting
- observed staff supporting patients
- spoke with three patients
- reviewed the care and treatment records of four patients
- reviewed a range of documentation relating to the running of the service

What people who use the service say

We spoke with three patients during our inspection on Peak View. We did not contact carers as part of this inspection as we had already spoken with parents and carers of patients on Peak View three weeks previously, as part of our comprehensive inspection of the whole hospital. Their views are included as part of our report of that inspection which took place in August 2017.

We offered all patients the opportunity to speak with us and three chose to. Two said they felt safe on the wards. One patient had a recent incident but said they did not feel staff could have prevented this from happening. One patient did not feel safe, as some young people had recently had to attend hospital following incidents in a short space of time. They felt staff did not manage their risks appropriately.

One of the patients was unhappy they could not have one to one time with a specific member of staff and felt penalised because of this. Apart from this issue, they said the care that they received was good. Another of the patients said staff were generally quite good and they could have one to one time. They said there were activities available but that it got boring at times with little to do. They said they had a care plan but were unsure about their plans for discharge as staff had not spoken to them about this.

Two of the patients spoke about complaints and said they would speak with staff if they had any concerns. One had made a previous written complaint and said they were satisfied with the outcome.

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 found that:

- Care plans did not always incorporate known risks relating to patients.
- Staff did not review care plans and risk assessments appropriately in response to incidents.
- Staff did not routinely update information in a timely manner or at all which meant it the care and treatment they provided did not always reflect patient's needs.
- Documentation was incomplete in some instances and stored in the wrong records. Some information was difficult to navigate.

Are services effective?

Since the last comprehensive inspection in August 2017 we have received no new information that would cause us to re-inspect this key question.

Are services caring?

Since the last comprehensive inspection in August 2017 we have received no new information that would cause us to re-inspect this key question.

Are services responsive?

Since the last comprehensive inspection in August 2017 we have received no new information that would cause us to re-inspect this key question.

Are services well-led?

Since the last comprehensive inspection in August 2017 we have received no new information that would cause us to re-inspect this key question.

Child and adolescent mental health wards

Safe

Are child and adolescent mental health wards safe?

Assessing and managing risk to patients and staff

Staff discussed patients' risks, incidents, observation levels and other relevant information within each shift handover which was how they were aware of current patient needs. Handovers were documented and stored electronically on the hospital's own computer system. Staff told us risks were documented within patient care records and risk assessments which they could refer to. Two staff members commented that if they had been off for a significant amount of time, such a period of annual leave or a sickness, then it was not always easy to obtain an overview of this information on their return.

Staff used a risk assessment tool known as the short-term assessment of risk. Staff had completed these in the records we looked at. Each patient had a 'staying safe' care plan to help inform what support they required to help manage their risks. We reviewed four patient records in detail and found information was not always complete, updated as required and did not always reflect known risks.

We found some issues with the content of care records regarding information unrelated to the patient and erroneous information. For example, one patient's care records contained section 17 leave forms for a different patient in their file. In another patient's records we found the care plans of a different patient which included personal sensitive information about them. We informed the ward manager so they could ensure the information was removed and returned to the correct files.

One patient's referral documentation included significant information about them which was not reflected in any of their care plans. The ward manager and other staff were unclear as to whether this information was correct or not when we queried this. Staff made further enquiries and later informed us the information was an error in the documentation and did not relate to the patient. We asked how they had determined this and were told that a staff member recalled a past discussion with the referrer to this effect. However, this was not documented anywhere in the patient's electronic or paper records. This meant, without the knowledge that this discussion this had taken place, the information in the patient's records still looked applicable. This was supported by the fact that staff were not able to state whether the information was correct or not without further investigation. The incorrect information could have led to the patient receiving inappropriate support

Staff did not always review patients care plans at the required frequency. In all care records we looked at we saw examples of this. This included two patients' staying safe care plans which should have been reviewed bi-weekly but the most recent reviews were the beginning of July 2017. Other care plans for the same patients had not been reviewed for several weeks which extended past the required duration for when they should be reviewed. In one case, a patient's care plan had not been reviewed since June 2017, even though the plan stated monthly reviews were required. This meant there was a risk that staff did not identify changes to risk levels and patients needs in a timely manner.

There was differing information in patients' records about their support needs. For example, one patient's current risk management plan stated they were on 15 minute observations for the risk of self-harm. Within the same document, it was recorded that the patient was on two to one observations due to risk of suicide. Another patient's care plan said they were on 15 minute observations but they were actually on two to one observations at the time of our visit. The ward manager told us their observation levels had recently changed but confirmed this had not been updated in their records. Thus had the potential to cause confusion for staff about patient's needs and what level of assistance they required.

Staff did not always update records and changes to patients care needs in a timely manner. We reviewed the records of the two patients subject to the incidents that had contributed towards our decision to undertake the inspection. These incidents occurred when the patients were on unescorted leave and resulted in the patients ultimately being treated in the general hospital before returning to Cygnet hospital. Following these incidents, the multidisciplinary team had suspended unescorted leave for the patients until further medical review. However, one

patient had taken unescorted leave off the ward as staff had not updated the necessary documentation with the new leave conditions. The error was later identified and we saw an incident report which led staff to update the information as required. The records of the second patient showed their leave recording form still authorised them as being able to take unescorted leave as their information had not been updated. There was no evidence to show the patient had taken any unescorted leave since the recent incident. We made the ward manager aware of this so they could ensure the information was correctly updated to help prevent a similar incident occurring. This meant that without timely updates to patient documentation there was a risk patients may be exposed to risk of harm.

Staff did not always record and review periods of patient leave consistently. We reviewed a variety of documentation including leave records and associated pre and post leave risk assessments that staff and patients were required to complete. These were not always fully completed. For example, where people went on home leave or escorted leave, the family member or escort had not always signed the assessment as required. In two instances where a patient had been on home leave, there was no information documented on the post risk assessment form about how the period of leave had gone. We cross checked the forms with the electronic records and saw the periods of leave were not documented. A senior staff member confirmed they should have been. Old leave forms were kept within the patient records which had the potential to cause confusion about which information was current. However, we also saw examples of fully completed pre and post leave risk assessments. Staff we spoke with told us they always undertook a risk assessment both prior to patients going on leave and upon their return. The sample of records we saw showed this was not always evidenced. This meant there was not a clear audit trail in all cases of when patients had taken leave, who with and how this had gone.

Staff did not always undertake a thorough response in relation to incidents and risk management. One patient had a risk assessment from July 2017, which scored their suicide risk as low. The patient's own views were that they did not feel this was an accurate reflection of this risk. It was documented the patient had a prior history of overdoses which was reflected in their 'staying safe' care plan. In August 2017, the patient took a significant overdose whilst on leave. There was no reference to this in the August multidisciplinary meeting minutes following the incident. In addition, the minutes were incomplete as there was no information documented in the 'risk discussion' section and the risk assessment was not filled in. The first reference to the incident was in the multidisciplinary meeting of 5 September 2017. The patient had a risk screening tool which staff had reviewed subsequent to the incident. This still scored the patient's suicide risk as 'low'. Staff had not updated the patient's care plan since the incident and therefore it included no information about any additional safeguards they may need.

We checked the hospital's electronic records in relation to this same incident. These showed the patient was taken to a general hospital for medical treatment. The responsible clinician reviewed the patient after they returned to the ward and there was a change to the patient's status at the service. A doctor had documented evidence of further reviews and staff took other actions such as searching the patient's room. Our review of the whole information showed that although staff took initial actions in response to the incident, they did not suitably review, update, and amend the patient's risk assessments and care plans. Records did not reflect that the multidisciplinary team had identified and mitigated against known and on-going risks in this instance. This meant there was potential the patient could have been exposed to risk of potential harm and unsafe care and treatment.

Patient records did not include details about how staff should support them when in a crisis. One patient had been in seclusion for several days prior to our visit. We reviewed the records for this patient and saw there had been two recent documented periods of seclusion. Staff had updated the patient's 'staying safe' care plan on 11 August 2017 with reference to the use of seclusion. There was no involvement of the patient within this and therefore no information about the patients wishes or requests with regard to seclusion as an intervention. There was no clear information about what staff should do if the patient displayed disinhibited behaviour which meant they may not be fully aware of how to prevent the need for seclusion. This lack of information related to issues we identified at our comprehensive inspection of August 2017. At that time, we found that care plans on the adolescent wards did not always include this level of information.

We offered all patients on Peak View the opportunity to speak with us and three chose to. Two said they felt safe on

the wards. One patient had a recent self-harming incident but said they did not feel staff could have prevented this from happening. One patient did not feel safe as some young people had recently had to attend hospital following incidents in a short space of time. They also told us of instances where they were secreting medicines and felt staff did not undertake appropriate checks in relation to this and were not vigilant. They said staff had updated their risk assessment to include an additional risk following a recent incident they had; however, this had always been a known risk for them. We checked the patient's records and confirmed that information showed this was correct and the risk was previously known but not recorded as such until after the recent incident. There was also no information in the care plans about the patient secreting medicines. This did not coincide with the patients own comments, a recent ward round summary and documented entries on the patient's electronic notes which referred to instances where this had happened. This demonstrated that staff did not effectively capture and review all patients known risks, including where such risks were already present.

Seclusion paperwork did not fully reflect the support patients received and was difficult to navigate. On the second day of our inspection, we reviewed the seclusion documentation for a patient who had recently been in seclusion. The information was completed in two separate books; one for the first 12 hours of seclusion and the second where seclusion extended beyond 12 hours as in this case. Entries were not always fully completed which meant it appeared as though some reviews had not taken place, or where they had taken place, had not met the required criteria such as having two nurses present at nursing reviews. The paperwork was hard to follow and did not provide a clear oversight of the patient's care and treatment whilst secluded. There was no record of authorisation to terminate seclusion so it appeared from the paperwork the patient was still in seclusion; however this was not the case. We reviewed the electronic notes of the seclusion episode and found these provided more detail which evidenced full discussions taking place and regular discussions in relation to ending seclusion. The termination of seclusion was documented on the electronic notes, along with the current plan of care for the patient which was a less restrictive arrangement. Our findings demonstrated that the records did not provide an accurate and clear summary in respect of the patient's care and treatment. At our comprehensive inspection of August 2017, we had identified some concerns in relation to seclusion. The quality assurance manager was in the process of reviewing the hospital's seclusion and long term segregation policy, part of which was to include reviewing the documentation that staff completed.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that risk assessments and care plans accurately reflect each patient's known risks. Staff must ensure these are updated when and where necessary, and in response to incidents where relevant. Patients must be able to contribute to, and inform these assessments and plans.
- The provider must ensure records relating to patients care and treatment are accurate, current, complete and that staff and patients, where appropriate, review these at the appropriate frequency.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment was not provided in a safe way for people using the service. Risk assessments were not always reflective of patients known risks. Staff did not always update risk assessments in response to incidents, including what further mitigation was required to reduce risk. Regulation 12

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**. Records of patients care were not always accurate, complete and did not include information about all decisions relating to their care and treatment. Regulation 17