Cygnet Health Care Limited

Cygnet Joyce Parker Hospital

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Insufficient evidence to rate
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Insufficient evidence to rate
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as requires improvement because:

- Not all staff were discreet, respectful, and responsive when caring for children and young people. We identified one incident of staff not treating a young person with dignity and respect on Pixie ward. Children and young people said staff did not always treat them well and behave kindly. Six young people across Mermaid and Pixie wards raised concerns about how staff treated them.
- Staff did not always follow best practice in managing distressed and agitated behaviours. We were concerned about the frequency of use of rapid tranquillisation for one young person which meant the young person was being sedated on an almost daily basis. When a child or young person was placed in seclusion, staff kept clear records but did not always follow best practice guidelines. We reviewed six seclusion records across Mermaid and Dragon wards and identified three concerns in relation to the use of seclusion.
- Not all wards were safe. We identified potentially risky items on Pixie ward and issues with the seclusion rooms on Dragon and Mermaid wards. Staff on Dragon ward did not always complete weekly emergency bag checks and did not always complete cleaning records for the clinic room.
- Our findings from the other key questions demonstrated that governance processes did not always operate effectively. Service governance systems failed to identify one concern relating to prolonged seclusion. Managers had not applied sufficient scrutiny, sought external assurance or a second opinion to support the care and treatment of a young person with complex needs who was frequently administered rapid tranquilisation medication.

However:

- Staff involved children, young people and their families in care planning and risk assessment. Staff made sure children and young people could access advocacy services. We observed effective advocacy involvement on all wards. Staff supported, informed and involved families or carers.
- Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed.
- The service had enough nursing and medical staff, who knew the children and young people. Staff completed and kept up-to-date with their mandatory training.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Requires Improvement 	Our rating of this service stayed the same. We rated it as requires improvement. See summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Joyce Parker Hospital

Cygnet Joyce Parker hospital is a Cygnet Healthcare Ltd location. The hospital provides care and treatment for children and young people between the ages of 12 and 18. There is an Ofsted registered school onsite.

The location is registered 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.

There was a registered manager when we carried out the inspection.

Cygnet Joyce Parker hospital opened on 15 October 2020. The hospital has four wards:

Mermaid ward is a mixed gender children and young peoples psychiatric intensive care unit, this ward has 10 beds and opened on 3 November 2020.

Pixie ward is a mixed gender general children and young peoples unit, this ward has 12 beds and opened on 15 February 2021.

Dragon ward is a mixed gender low secure ward with 10 beds and opened on 15 February 2021.

Faun ward is a child and young females psychiatric intensive care unit, this ward has 8 beds and opened on 11 October 2022.

This service has been inspected three times since it opened. The last inspection was in February 2022. This was a comprehensive inspection, and the service was rated requires improvement overall. Requirement notices were issued for breaches of regulations 13 (Safeguarding service users from abuse and improper treatment) and 17 (Good governance).

We found that the provider had addressed most of the breaches identified at the previous inspection. Whilst seclusion rooms on wards were available to be used, we found issues in two of them. On Dragon ward we identified issues with the vision through one glass viewing panel being obscured, a broken light and blind. The seclusion room on Mermaid ward was cold. Staff involved young people in their care plans. Managers reduced blanket restrictions across wards, but children and young people were still reliant on staff to access hot drinks.

What people who use the service say

We spoke with 15 children and young people using the service. We received a mix of positive and negative feedback. A young person on Dragon ward was positive about the service, telling us that staff were brilliant, facilities and activities were good. They expressed concerns about too many agency staff and staff sharing details about their personal lives. Negative feedback for Mermaid ward included young people not being listened to, staff not caring, staff not responding to incidents, lack of staff consistency in approach and lack of leave and activities. Only one young person spoke

Summary of this inspection

positively about the ward and told us staff were kind, approachable, respectful and easy to talk to and the ward was safe and clean. Children and young people on Pixie ward told us the ward was safe and clean and staff were generally good. They raised concerns that the ward could be loud and traumatic, staff did not always listen to concerns and there were not enough activities. One young person on Faun ward told us staff were supportive and they had no concerns.

How we carried out this inspection

We carried out this focused inspection in response to concerns raised in October 2022 by staff that included a bullying and blame culture developing, managers ignoring staff concerns, staff not supported following incidents, allegations of racism, staff being assaulted, young people being assaulted, managers not reporting safeguarding as required and unprofessional conduct.

We have reported in all the five key questions; safe, effective, caring, responsive and well led. We have rated safe, caring and well led as we looked at all key lines of enquiry under safe and well led and the rating of caring was changed to requires improvement due to breaches identified. We looked at specific key lines of enquiry for the other key questions in line with concerning information received. Therefore, our report does not include all the headings and information usually found in a comprehensive inspection report.

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

During the inspection visit, the inspection team:

- visited all wards and looked at the quality of the ward environment and observed how staff were caring for children and young people;
- spoke with 15 children and young people who were using the service;
- spoke with 5 carers/relatives;
- interviewed the nurse managers for the wards;
- interviewed 1 senior manager;
- spoke with 18 other staff members; including nurses, healthcare assistants, consultant psychiatrists, speciality doctors, occupational therapists, psychologists and the safety intervention lead.
- looked at 22 care and treatment records of children and young people;
- reviewed 6 incident records;
- reviewed closed circuit television footage of 5 incidents;
- observed 5 meetings/activities etc

Looked at a range of policies, procedures and other documents relating to the running of the service.

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

Areas for improvement

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

Summary of this inspection

Action the service MUST take to improve:

- The service must ensure ward environments, including seclusion rooms, are safe for children and young people and staff. (Regulation 12 (1) (2) (d))
- The service must ensure that staff complete all required safety checks and cleaning records. (Regulation 12 (1) (2) (d))
- The service must ensure use of rapid tranquillisation is adequately scrutinised to ensure it is only used when necessary. (Regulation 12 (1) (2) (g))
- The service must ensure staff follow best practice guidelines when secluding children or young people and that all incidents of seclusion are reported and managed appropriately. (Regulation 12 (1) (2) (c))
- The service must ensure all staff are discreet, respectful, and responsive when caring for children and young people. (Regulation 10 (1))
- The service must ensure service governance systems are able identify all issues of concern. (Regulation 17 (1) (2) (a)(b))
- The service must ensure managers seek external assurance or a second opinion to support the care and treatment of any child or young person with complex needs who is subjected to a non-standard treatment regime. (Regulation 17 (1) (2) (e))

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Requires Improvement	Insufficient evidence to rate	Requires Improvement	Insufficient evidence to rate	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Insufficient evidence to rate	Requires Improvement	Insufficient evidence to rate	Requires Improvement	Requires Improvement

Requires Improvement

Child and adolescent mental health wards

Safe	Requires Improvement
Effective	Insufficient evidence to rate
Caring	Requires Improvement
Responsive	Insufficient evidence to rate
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

Not all wards were safe. Wards were generally clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified on Mermaid, Dragon and Faun wards. On Pixie ward we raised concerns about staff using a storage room for children and young people's belongings to store other, potentially risky, items. We raised this with the ward manager who advised they would remove all the risk items items not belonging to patients.

Staff could observe children and young people in all parts of the wards. Managers mitigated blind spots through the installation of mirrors, closed circuit television cameras and staff observation.

The wards complied with guidance on mixed gender accommodation. All bedrooms had en-suite shower and toilet facilities which meant that children and young people did not have to pass other people's bedrooms to wash. All wards had female only lounges.

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe by limited or supervised access to high risk areas, relational security and individual risk assessments.

Staff had easy access to alarms and children and young people had easy access to nurse call systems. Personal alarms were issued to staff and visitors by reception staff upon entering the building. These were tested regularly, and it was the responsibility of reception staff to ensure that they were charged and well maintained.

Maintenance, cleanliness and infection control

Requires Improvement

Child and adolescent mental health wards

Ward areas were clean, well maintained, well furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing. Managers completed audits of infection control and handwashing and took action to address any concerns. One example included managers reminding staff of the need to be bare below the elbow. We observed staff to be bare below the elbow during the inspection.

Seclusion room

Seclusion rooms allowed two-way communication. They had a toilet and a clock. Seclusion rooms on Mermaid and Pixie ward allowed clear observation. On Dragon ward staff were unable to see through one of the two glass vision panels, one light and the blind controls were also not working. However, staff were able to view the room via CCTV and the provider changed the lightbulb during the inspection. The seclusion room on Mermaid ward was very cold as staff left the window open. Although the room was not in use at the time, it would have been very cold for any child or young person needing to use it. We raised this and staff immediately closed the window. Following the inspection the provider advised the window was left open to allow fresh air flow when the room was not in use and the room could be quickly heated if required.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs. We found staff on Dragon ward did not always complete weekly emergency bag checks. We saw checks were not completed between 25 December 2022 and 14 January 2023.

Staff checked, maintained, and cleaned equipment on Mermaid, Pixie and Faun wards. Staff on Dragon ward did not always complete cleaning records for the clinic room.

Safe staffing

The service had enough nursing and medical staff, who knew the children and young people and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep children and young people safe. The provider reported a shift fill rate of 108% between 01 January 2022 and 31 December 2022. This data was not broken down into qualified and unqualified roles.

The service had low vacancy rates. The provider reported 2 full time equivalent qualified vacancies and no unqualified vacancies. The provider advised they are aiming to recruit to 150% of their establishment for unqualified staff. This would remove the need for agency staff.

The service had reducing rates of bank and agency nurses. The provider reported 418 shifts filled by qualified agency staff and 4,302 shifts filled by unqualified agency staff between 01 January 2022 and 31 December 2022.

Requires Improvement

Child and adolescent mental health wards

The service had reducing rates of bank and agency nursing assistants. The provider reported 16 shifts filled by qualified bank staff and 2,173 shifts filled by unqualified bank staff between 01 January 2022 and 31 December 2022.

Managers requested bank and agency familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

At the time of our inspection the hospital reported turnover rates of 14% in the three months prior to our visit. This was the same rate as reported at our previous inspection.

Managers supported staff who needed time off for ill health.

Levels of sickness were low and reducing. The provider reported sickness rates of 2% in the six months prior to our inspection.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.

The ward manager could adjust staffing levels according to the needs of the children and young people.

Children and young people had regular one to one sessions with their named nurse. A system in place for children and young people to be allocated named nurses and key workers meant that every child and young person had an allocated individual on both shift patterns during the day.

Children and young people rarely had their escorted leave, or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep children and young people safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the wards quickly in an emergency. Junior doctors had an on-call rota to ensure that the units always had access to a doctor out of hours. In line with the provider's policy, on call doctors were expected to be within a twenty-minute drive from the hospital. If this was not possible there was a doctor on call suite on site for allocated doctors to use during their period of cover.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff completed and kept up-to-date with their mandatory training. The provider reported a compliance rate of 94% for staff mandatory training as of 17 January 2023.

Requires Improvement

Child and adolescent mental health wards

The mandatory training programme was comprehensive and met the needs of children and young people and staff.

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

Assessing and managing risk to children and young people and staff

Staff assessed and managed risks to children, young people and themselves well. Staff did not always follow best practice in anticipating, de-escalating and managing distressed or agitated behaviours. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of young person risk

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 22 care records which contained completed and regularly reviewed risk assessments.

Management of young person risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, children and young people. Ward teams met daily to review each child and young person's risk and agree on the level of observation required and any changes to the child or young person's risk management plan.

Staff could observe children and young people in all areas. The service complied with Cygnet's 'Safe and Supportive Observations policy'. We reviewed 3 observation records which evidenced this.

Staff followed the provider's policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm.

Use of restrictive interventions

We reviewed data that showed most physical interventions were lower level in line with provider policies and procedures, and the use of supine or prone restraint was rare. The service security and safety intervention lead reviewed any restraint incident over 10 minutes and all incidents of prone restraint. We reviewed four incidents of restraint on closed circuit television. All incidents were managed appropriately. The provider identified learning from one of the incidents which involved a prolonged episode of attempted self-harm and multiple restraints.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff attended the restrictive interventions training course as part of their induction and undertook refresher training annually.

The service reported 932 incidents of restraint from 01 January 2022 and 31 December 2022: 598 for Mermaid ward, 174 for Dragon ward, 133 for Pixie ward and 27 for Faun ward.

The service reported 28 incidents of prone restraint from 01 January 2022 and 31 December 2022: 21 for Mermaid ward, 3 for Dragon ward, 2 for Faun ward and 2 for Pixie ward.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

The service reported 96 incidents of rapid tranquilisation between 01 January 2022 and 31 December 2022: 73 for Mermaid ward, 10 for Pixie ward, 8 for Faun ward and 5 for Dragon ward. We reviewed records that showed staff completed physical health observations following rapid tranquillisation. Although staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation, we were concerned about the frequency of use of rapid tranquillisation for one young person. The daily dosage was within British National Formulary limits, but the frequency (59 occasions over 42 days) meant the young person was being sedated on an almost daily basis. Ward round minutes for this young person described the use of rapid tranquillisation as “regular PRN”. Senior staff advised this was necessary to prevent more serious harm occurring and this was detailed in the young person’s care plan. We reviewed minutes of team meetings and reflective practice sessions where staff raised their concerns about the treatment plan for this young person. The multi-disciplinary team reduced the dosage of rapid tranquillisation medicines by half to minimise the impact of sedation on the young person. Following the inspection, the provider shared minutes from a multi-agency meeting which stated that the use of rapid tranquillisation had significantly reduced.

When a child or young person was placed in seclusion, staff kept clear records but did not always follow best practice guidelines. The service reported 87 seclusion incidents between 01 January 2022 and 31 December 2022: 48 for Mermaid ward, 33 for Dragon ward, 4 for Faun ward and 2 for Pixie ward. We reviewed six seclusion records across Mermaid and Dragon wards and identified three concerns in relation to the use of seclusion. We identified a potential seclusion episode during a restraint incident viewed on closed circuit television on Dragon ward. The provider confirmed the young person was secluded for 28 minutes and staff had not reported this and did not commence seclusion procedures as required. The provider is investigating this incident. The second concern related to a seclusion episode on Mermaid ward where the young person was informed by the nurse at 01:10 that she would be spending the night in seclusion despite there being no recorded evidence of risks continuing. Following the initial medical review at 20:04 on the 3 January 2023 there was no medical review until 10:26 on 4 January 2023 when seclusion was terminated. This was not in line with the Mental Health Act Code of Practice which states “Continuing four-hourly medical reviews of secluded patients should be carried out until the first (internal) MDT has taken place including in the evenings, night time, on weekends and bank holidays. A provider’s policy may allow different review arrangements to be applied when patients in seclusion are asleep." We reviewed the provider's seclusion guidance which states medical reviews only need to take place twice daily, there was no reference to this only being when secluded patients were asleep. The third concern related to a seclusion on Dragon ward which continued after a medical review, despite the young person presenting as “settled, apologetic and engaging”. We saw evidence that the medical director raised concerns about this seclusion at the time. We were concerned that young persons were at risk of being secluded for longer than required.

The provider reported 5 episodes of long-term segregation between 01 January 2022 and 31 December 2022: 4 on Pixie ward and 1 on Mermaid ward. Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a child or young person was put in long-term segregation. We reviewed records of two episodes of long-term segregation which evidenced this.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. The provider reported 93% compliance rate for staff as of 17 January 2023.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff discussed safeguarding concerns in the daily reviews for each young person.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

We reviewed a safeguarding incident from October 2022 involving an external visiting professional. Staff raised concerns to the previous senior management team about this incident and requested that it be reported to the local authority safeguarding team. When this did not happen, staff raised directly with CQC and a safeguarding referral was made.

Staff followed clear procedures to keep children visiting the ward safe. There were visiting rooms, suitable for children, located off the main wards.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

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

Children and young people's notes were comprehensive and all staff could access them easily.

The organisation used an electronic recording system that required staff to fill in all sections of the document. When children and young people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We inspected clinic rooms on Mermaid and Dragon wards and reviewed 8 medicines charts which evidenced this.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines. This was reflected in multi-disciplinary meetings observed and minutes of meetings reviewed.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check children and young persons had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

Although decision making processes were in place to ensure children and young people's behaviour was not controlled by excessive and inappropriate use of medicines we found one example of high use of rapid tranquillisation.

Staff reviewed the effects of each child or young person's medication on their physical health according to the National Institute for Health and Care Excellence guidance.

Track record on safety

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with provider policy. The service reported 1,200 incidents between 01 October 2022 and 31 December 2022. Three were severe incidents (all on Dragon ward), 9 were moderate, 186 minor and 1,005 resulted in no or negligible harm. The most common incident type was self harm/ attempted self harm (681) followed by actual violence and aggression (339).

Staff reported serious incidents clearly and in line with trust policy.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong. We saw evidence of this in incident records reviewed.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. We saw evidence of this in incident reports and investigations reviewed.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw evidence of this in minutes of meetings and from speaking with staff. Managers shared an example of a young person secreting gravel in the sole of their shoe to use to self harm, learning from this was shared across the organisation.

Requires Improvement

Child and adolescent mental health wards

There was evidence that changes had been made as a result of feedback. One example included changes made to housekeeping processes following an incident where a young person grabbed a bottle of cleaning fluid and drank it.

Is the service effective?

Insufficient evidence to rate

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after. We reviewed 22 care records that evidenced this.

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We reviewed 22 care records that evidenced this.

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs. We reviewed 22 care records that evidenced this. Staff completed thorough positive behaviour support plans with young persons.

Staff regularly reviewed and updated care plans when children and young people's needs changed. We saw evidence of this in records reviewed and meetings observed.

Care plans were personalised, holistic and recovery orientated.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of children and young people on the ward(s). Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills.

The service had (access to) a full range of specialists to meet the needs of the children and young people on the ward. This included psychologists and occupational therapists.

Managers supported staff through regular, constructive clinical supervision of their work. The provider reported a compliance rate of 97%.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We saw minutes from team meetings which evidenced this.

Requires Improvement

Child and adolescent mental health wards

Managers recognised poor performance, could identify the reasons and dealt with these. We reviewed a case of poor performance management which resulted in staff not passing their probation.

Multi-disciplinary and interagency team work

The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Ward teams had effective working relationships with external teams and organisations. This was evidenced through feedback from external professionals and minutes of interagency meetings.

Is the service caring?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Not all staff treated children and young people with compassion and kindness. They did not always respect children and young people's privacy and dignity.

Not all staff were discreet, respectful, and responsive when caring for children and young people. A young person on Pixie ward told us about a member of staff not treating them with dignity and respect in relation to supporting them with personal hygiene needs. The young person and their family complained and the provider took immediate action to address. We reviewed minutes of a community meeting on Mermaid ward where a young person raised concerns about male staff supporting with changing dressings, which made them feel uncomfortable. The provider advised they changed the young person's care plan following these concerns being raised. Two young people on Pixie ward raised concerns about actions of male staff causing distress. The provider shared the investigation for these complaints which were not upheld.

Staff gave children and young people help, emotional support and advice when they needed it.

Staff supported children and young people to understand and manage their own care treatment or condition.

Children and young people said staff did not always treat them well and behave kindly. We spoke with 4 young people on Mermaid ward and 3 raised concerns about how staff treated them, with one telling us that staff don't care. We spoke with 4 young people on Pixie ward and all 4 told us most staff were kind and caring with 2 raising concerns about the specific incidents with male staff. We spoke to one young person on Dragon ward who told us staff were fantastic and one young person on Faun ward who said staff were supportive and they had no concerns.

Involvement in care

Requires Improvement

Child and adolescent mental health wards

Staff involved children, young people and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that children and young people had easy access to independent advocates and to child helplines.

Involvement of children and young people

Staff introduced children and young people to the ward and the services as part of their admission.

Staff involved children and young people and gave them access to their care planning and risk assessments. Care records reviewed evidenced this.

Staff made sure children and young people understood their care and treatment (and found ways to communicate with children and young people who had communication difficulties). We saw evidence of this in meetings observed and care records.

Staff involved children and young people in decisions about the service, when appropriate. The provider held a quarterly Child and Adolescent Mental Health Services People Council. We reviewed meeting minutes for December 2022. This was attended by a child or young person representatives from all 3 Cygnet Child and Adolescent Mental Health Services, including 2 from Cygnet Joyce Parker. The minutes evidenced discussion of restrictions, looking for a consistent approach and sharing good practice. One of the service young people's representatives was involved in interviewing staff, co-producing training sessions and creating an admission pack for the ward.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. We reviewed minutes of 10 community meetings that took place between October 2022 and January 2023 which evidenced this.

Staff supported children and young people to make decisions on their care. This was evidenced in care records reviewed and from speaking with patients.

Staff made sure children and young people could access advocacy services. We observed effective advocacy involvement on all wards. including rotating attendance at daily review meetings. We reviewed the advocates quarterly report (September- December 2022) which recorded a total of 193 individual advocacy sessions with patients across all wards.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke with 5 carers for young people on Mermaid, Pixie and Faun wards who told us this. We observed good communication and involvement of carers in discussions during the daily ward reviews of young people and evidence of carer involvement in care plans and reviews. One carer told us that staff were doing an amazing job. One carer said the doctors and nurses were brilliant but was concerned that some of the unqualified staff lacked experience.

Carers were provided with a carers passport which detailed key contacts and how they could be involved.

Requires Improvement

Child and adolescent mental health wards

Is the service responsive?

Insufficient evidence to rate

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported children and young people's treatment, privacy and dignity. Each child and young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and children and young people could make snacks and cold drinks at any time but were reliant on staff for hot drinks.

Each child or young person had their own bedroom, which they could personalise.

Children and young people had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where children and young people could meet with visitors in private.

Children and young people could make phone calls in private. Children and young people were able to have their own mobile phones, if assessed as safe, or were able to use the ward cordless phone in their bedroom.

The service had an outside space that children and young people could access easily.

Children and young people could access their own snacks and cold drinks and were not dependent on staff. Children and young people were reliant on staff for hot drinks on all wards apart from Pixie ward. The provider fitted a hot water dispenser on Pixie ward for young people to make hot drinks independently and advised all wards would be fitted with these by March 2023.

The service offered a variety of good quality food. Children and young people told us the food was generally good.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Children, young people, relatives and carers knew how to complain or raise concerns. Children and young people and carers spoken with told us this.

The service clearly displayed information about how to raise a concern in children and young people's areas.

Staff understood the policy on complaints and knew how to handle them. The provider reported receiving 36 complaints between 01 July 2022 and 31 December 2022. These were received from carers and patients. 14 complaints

related to concerns about therapeutic interventions and six to communication issues. All complaints were logged at stage 1, internal resolution. We reviewed one young person with a prolific complaints care plan. The young person was supported weekly by the provider's Child and Adolescent Mental Health Services lead (external to the service) to discuss their concerns.

Managers investigated complaints and identified themes. We reviewed a complaints investigation report that evidenced this.

The service used compliments to learn, celebrate success and improve the quality of care. The provider reported 80 compliments received between 01 July 2022 and 31 December 2022. These were received from children and young people, carers, external health professionals and staff. Examples included "Joyce Parker was literally the only place I've found that's supported me" (young person), "We were genuinely so impressed at the change in X and the way we observed your team engage her, communicate with her and make positive and proactive planning to get the best for her" (external health professional) ""Mum wants to pass on her thanks to the whole team for all of the support the team has given her" (carer) and "Pixie Ward is probably my favourite GAU due to their team and care given" (commissioner).

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children, young people, families and staff.

Staff were positive about the leadership and support of the returning hospital director. The provider's senior leadership team acted swiftly to address concerns raised by staff about the previous leadership team at the service. This included bringing the previous hospital director back from another role within Cygnet and regular visits to the service to support staff.

Vision and strategy

Staff knew and understood the provider's vision and values and how they should be applied to the work of their team.

The provider's values were integrity, trust, empower, respect and care. We reviewed supervision records where staff described how they applied the provider's values in their work.

Culture

Requires Improvement

Child and adolescent mental health wards

Staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

The provider had a network of Freedom to Speak Up Ambassadors available to support all staff to discuss and raise concerns they may have. Staff spoken with told us they were confident to raise concerns.

We reviewed a staffing survey completed between 24th February and 7th April 2022. 27% of respondents said their colleagues and rewarding work made them stay and 24% wanted better pay and benefits. Staff feedback was mostly positive about managers and the service. Some staff raised concerns about staffing levels, breaks being too short, lack of sick pay and environmental issues.

Staff reported there had been low morale on Dragon ward due to a number of incidents and the impact on staff. Staff told us they have been supported though de-briefs and informal chats. Staff told us the ward was more settled following recent management changes.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively. Senior staff did not always ensure effective governance of risks.

The service governance systems failed to identify one concern relating to prolonged seclusion, environmental issues in seclusion rooms and clinic room checks.

Managers had not applied sufficient scrutiny, sought external assurance or a second opinion to support the care and treatment of a young person with complex needs who was being administered high levels of rapid tranquilisation medication.

We reviewed minutes from 3 governance meetings for November and December 2022 and January 2023. These meetings used the STEELL agenda- Safety, Training and Education, Effectiveness (Clinical effectiveness), Experience (Patient and Carer), Lessons Learnt. Minutes evidenced detailed discussions of risks, restrictive practices, outcomes of audits and feedback from community meetings.

The service evidenced effective governance between wards and the senior management team. We observed one daily senior management meeting which followed on from ward based daily reviews. Ward manager fed back on their risk areas including individual children and young people concerns, incidents, safeguarding concerns and staffing.

We reviewed daily senior management meeting records for January 2023. These evidenced issues raised in the daily ward meetings being escalated to the senior leadership team and actions being agreed.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Managers used dashboards to effectively manage their teams.

Requires Improvement

Child and adolescent mental health wards

We reviewed audits completed by the quality lead and security lead. These included audits of observation, engagement and closed circuit television. This included a sample of 4 staff observation and engagement training compliance, a sample of 4 children and young people observation records and a closed circuit television review of staff on 4 different young persons observations.

We reviewed the service risk register. Managers rated their open risks as red, amber or green. There were no open red risks.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The service was part of the local Child and Adolescent Mental Health Services provider collaborative.

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 10 HSCA (RA) Regulations 2014 Dignity and respect • Not all staff were discreet, respectful, and responsive when caring for children and young people.

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 • Service governance systems did not identify all issues of concern. • Managers did not seek external assurance or a second opinion to support the care and treatment of a young person with complex needs subjected to a non-standard treatment regime.

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 Not all ward environments were safe for children young people and staff. Staff did not complete all required safety checks and cleaning records. Senior leaders did not adequately scrutinise the use of rapid tranquillisation. Staff did not always follow best practice guidelines when secluding children or young people.

This section is primarily information for the provider

Requirement notices

Managers did not always ensure all incidents of seclusion were reported and managed appropriately.