Cygnet Hospital Godden Green

Quality Report

Godden Green
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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

On the 2 and 3 November 2017, the Care Quality Commission carried out an urgent responsive inspection on Knole ward and Littleoaks. Concerns had been raised with us, including the number and severity of incidents affecting the health, safety and welfare of young people on the wards, the lack of reporting of incidents to relevant external authorities and the safety of the ward environment.

We found the service provider to be in breach of regulation 12, safe care and treatment, regulation 13, safeguarding service users from abuse and improper treatment, and regulation 17, good governance. We took enforcement action and issued three warning notices under each of the regulations on 23 November 2017. The warning notices served notified the provider that the Care Quality Commission had judged the quality of care being provided as requiring significant improvement. We told the provider they must comply with the requirements of the regulation by 15 January 2018. We had previously taken enforcement action and had already issued a warning notice against the provider for breach of regulation 13, safeguarding service users from abuse and improper treatment, following our last inspection in July, August and September 2018.

We also issued the provider with fixed penalty notices under sections 86 and 87 of the Health and the Social Care Act and under Regulation 28 and Schedule 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The fixed penalty notices were issued in relation to multiple failures by the provider to make required notifications to the Care Quality Commission.

A further comprehensive inspection is scheduled to commence on 20 February 2018, where we will look to see what action the provider has taken in respect of each of the breaches of regulation.

We found the following issues the service provider needs to improve:

- Environmental risk assessments for the wards did not always identify risks that required escalation. We saw examples where incidents had occurred in the environment and assessments were not updated to manage or prevent similar incidents being repeated.
- The quality of individual risk assessments for young people were poor. Staff did not update or review risk

Summary of findings

assessments following incidents. The risk of similar incidents being repeated was not mitigated or managed. We saw several examples where similar, preventable incidents reoccurred.

- Staff were not always competent and skilled to provide care and treatment to young people. Staff had required police assistance on a number of occasions to support and manage incidents on the wards that should not have required the support of the police.
- Staff were not always supported to prevent, identify and report abuse. Staff were not skilled in making safeguarding referrals to the local authority safeguarding team.
- Staff did not fully investigate safeguarding concerns and not all safeguarding concerns were reported internally or to the relevant external agencies. We found a number of incidents that had not been appropriately reported.
- The provider did not always support young people following incidents and provide feedback.
- Incident forms were poorly completed and missing information. Staff were not following the provider's process for incident reporting correctly. The provider did not keep an up to date, accurate and complete record of incidents on the wards.
- The provider did not have effective audit and governance systems in place to monitor the service. There was no effective system in place to ensure there was learning from incidents and action taken to mitigate future risks.

Summary of findings

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Summary of this inspection

Background to Cygnet Hospital Godden Green

Cygnet Hospital Godden Green has an integrated Tier 4 child and adolescent mental health service alongside a Department for Education, Ofsted -registered school, the Knole development centre. Their specialist pathway offers an open acute admissions service (Knole ward), and a pre-discharge ward (Littleoaks) to allow for a smooth transition for young people returning home to their families. The hospital also operates a low secure forensic service for men (Saltwood) that is run in joint working arrangement with Kent and Medway Partnership NHS Trust.

During the course of this inspection, we focussed on Knole ward, which comprised of 16 en-suite bedrooms, and Littleoaks, which comprised of eight en-suite bedrooms, both for males and females aged between 12-18 years of age.

Cygnet Hospital Godden Green is registered for the following regulated activities: assessment or medical treatment, for persons detained under the Mental Health Act 1983; treatment of disease, disorder or injury.

The registered manager for the service is Danmore Padare.

We last inspected this service during a series of unannounced and announced focused inspections on 25 and 26 July 2017, 4 August 2017 and 8 August 2017. Following these inspections we took enforcement action and issued an urgent notice of decision under section 31 of the Health and Social Care Act to impose conditions on the hospitals registration in relation to Knole ward. We told the provider they must not admit any young person to Knole ward without prior agreement of the Care Quality Commission. This was because we believed following those inspections a person could or would be have been exposed to the risk of harm. The notice of decision contained six positive conditions the provider had to make improvements against. We inspected the service again on 4 and 5 September 2017 to find out if the service had made improvements to Knole ward. We specifically looked at the concerns identified in the urgent notice of decision. During that inspection we found the service had made some significant improvements to the safety and quality of treatment provided to young people. We were satisfied appropriate action had been taken to ensure young people were no longer exposed to the risk of harm. On 8 September 2017 we lifted all the conditions set out in the urgent notice of decision and told the provider they could then admit young people to Knole ward.

Our inspection team

Team leader: Hannah Cohen-Whittle

The team that inspected Knole ward and Littleoaks comprised CQC inspection manager and two CQC inspectors'.

Why we carried out this inspection

We undertook an unannounced, focused inspection, following concerns including the number and severity of incidents affecting the health, safety and welfare of young people on the wards, the lack of reporting of incidents to relevant external authorities and the safety of the ward environment.

As this was not a comprehensive inspection, we did not pursue all of our key lines of enquiry. We visited both of the child and adolescent mental health wards at this location. Therefore, this report does not indicate an overall judgement or rating of the service. Our resources were focussed on inspecting the current areas of alleged concern and this should be considered when reading this report.

Summary of this inspection

How we carried out this inspection

During this inspection we considered areas of the service to make a judgement on the following questions:

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

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations and professionals for information.

During the inspection visit, the inspection team:

- visited Knole ward and Littleoaks at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with nine young people who were using the service;
- spoke with the Operations Director, Interim Clinical Manager and Corporate Safeguarding Lead,
- looked at seven care and treatment records of young people;
- reviewed incident forms and safeguarding records;
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

We spoke with nine young people who told us they did not always feel safe on the wards. Young people told us staff were not always responsive to their needs. Young people also told us staff sometimes did not respond to incidents in a timely way and they did not always receive feedback following an incident. Young people told us staff were variable, and while there were certain staff who they described positively, there were also staff who they felt did not listen to their needs. We were told that the provider did not inform young people the outcome of incidents and when other external agencies/bodies had been involved.

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 the following issues that the service provider needs to improve:

- The environmental risk assessments for the wards were not always capturing risks that required escalation. We saw examples where incidents had occurred in the environment and assessments were not updated to manage or prevent similar incidents being repeated. We also found an example where equipment had failed to be operational and this had not been identified by the provider's internal control measures.
- We found the overall quality of individual risk assessments for young people to be poor. Staff did not update or review risk assessments following incidents. The risk of similar incidents being repeated was not mitigated or managed. We saw several examples where similar incidents reoccurred.
- Staff were not skilled in how to raise safeguarding alerts when required to do so. Staff did not take timely action when they had been alerted to suspected, alleged or actual abuse. Staff did not fully investigate safeguarding concerns and not all safeguarding concerns were reported internally or to the relevant external agencies. We found a number of incidents that had not been appropriately reported.
- Incident forms were not completed fully and lacked required information. This meant the provider was unable to review incidents fully and take action to prevent future reoccurrences and support staff in the management of risks. The provider did not always support young people following incidents and provide feedback.

Are services effective?

We found the following issues that the service provider needs to improve:

- Staff were not always competent and skilled to provide care and treatment to young people. Staff had required police assistance on a number of occasions to support and manage incidents on the wards. Staff were not provided with the skills to manage incidents and to manage future risks.
- Staff were not always supported to prevent, identify and report abuse. Staff were not skilled in making safeguarding referrals to the local authority safeguarding team.

Summary of this inspection

Are services well-led?

We found the following issues that the service provider needs to improve:

- The provider did not have effective audit and governance systems in place to monitor the service. There was no effective system in place to ensure there was learning from incidents and action taken to mitigate future risks. The oversight of safeguarding was not appropriate. The provider did not maintain an accurate and up to date safeguarding log that detailed the actions taken and if a referral had been appropriately made or the outcome or any referral.
- The provider did not always escalated incidents appropriately internally or to the relevant external agencies/bodies.
- The provider did not keep an up to date, accurate and complete record of incidents on the wards. We found the completion of incident forms was variable and lacked sufficient detail to ensure the wards were sighted on risks and supported to prevent and manage future risks. The process of incident reporting was not being followed correctly and being signed off or reviewed appropriately.

Child and adolescent mental health wards

Safe	
Effective	
Well-led	

Are child and adolescent mental health wards safe?

Safe and clean environment

- We found environmental risk assessments did not always capture risks to ensure they were escalated and remedied. The assessments were not updated once a risk had been identified or following an incident. For example, a fire door on Littleoaks ward was left unlocked and unmanned and led directly to the stairs of the main hospital. When exiting the ward through the fire door there was a door leading into the main hospital kitchen that was unlocked and would have been accessible to a young person had they exited the ward through the fire door. The hospital kitchen contained numerous dangerous objects that could have been used for self-harming behaviour or to harm other young people or staff. We raised this with the provider during the inspection and immediate action was taken. On Knole ward, we found furniture in the garden area that had been used twice by young people to climb onto the roof of the conservatory. The furniture had remained in the garden until we raised this with the provider during the inspection. Immediate action was taken and the garden furniture was removed. We were given assurances that when the furniture was returned it would be bolted down so it could not be moved to climb onto the roof.
- We found the provider did not always ensure the safety of the premises and equipment in it. There were no control measures in place to keep the risks as low as possible and to address identified risk. For example, between 6 September and 11 October 2017 the closed circuit television system on both wards was failing to record. The provider should have been undertaking weekly audits to be satisfied that the system was operational but failed to do so. The closed circuit television system was in place to investigate and learn from incidents and also to maintain the safety of young people on the wards. As the closed circuit television was not recording, it could not be used for these activities. We raised this with the provider during the inspection and immediate action was taken.

Assessing and managing risk to patients and staff

- We reviewed seven risk assessments of young people during the inspection. We found staff did not update or review risk assessments of young people on the wards after every incident. The lack of review of risk assessments following incidents meant risks relating to young people were not mitigated and did not reduce the risk of similar incidents being repeated. For example we found repeated incidents of physical and emotional harm on the wards, these included physical violence between young people, swallowing of objects and ligature tying.
- Risk assessments about the health, safety and welfare of young people on the wards were not used to make required adjustments. Risk management plans were not updated to reflect when the risk of a young person had increased following an incident and did not address how such risks could be managed appropriately to respond to young people's challenging needs. For example, we saw repeated types of incidents on the wards including two incidents where young people had climbed onto the conservatory roof using garden furniture that was moved as it was not fixed to the floor. The first incident happened on 22 October 2017. Following the incident risk management plans and assessments were not updated and no action was taken to mitigate the risk. On 29 October 2017 the incident was repeated again when another young person climbed onto the conservatory roof using the garden furniture.
- Staff were unaware of how to raise a safeguarding alert and when it was appropriate to do so. Staff did not always take appropriate action as soon as they were alerted to suspected, alleged or actual abuse, or the risk of abuse. Staff did not ensure such instances were fully investigated. During the inspection, we found a high level of incidents that should have been escalated to the local authority safeguarding team to seek specialist

advice and support. The provider did not report a many of these incidents for a considerable time after the incident had happened. We also found incidents that were not reported at all. This meant that young people were put at risk of further harm and/or abuse. We found where incidents had been escalated to the relevant external bodies, the provider did not always find out the outcome of the referral. Staff were unable to therefore respond without delay to the findings of any investigations and take the required action to ensure abuse was not repeated. This was contrary to the provider's policy which states "following the referral to social care, they should notify what the outcome of the referral has been. If you have not heard an outcome of the referral within three working days. The ward/unit should follow up and request an outcome to the referral from social care".

- The provider did not use incidents to identify when potential abuse had happened. We found high levels of incidents that were repeated and the provider had not taken preventative action where appropriate. For example, we found multiple incidents of young person on young person physical and emotional harm. This was contrary to the provider's policy which states "in situations where the hospital considers a safeguarding risk is present, a risk assessment should be prepared along with a preventative, supervision plan. The plan should be monitored and a date set for a follow-up evaluation with everyone concerned".

Reporting incidents and learning from when things go wrong

- During the inspection we reviewed the wards incident logs and the care records of seven young people. We found incident forms were poorly completed and lacked detailed information. It was unclear how incidents had escalated and in some instances why police support on the wards had been required. Information such as the young person's hospital identification code were found to be missing on some forms. Where two staff members had reported the same incident the descriptions of the incident differed. The actions detailed on the incident forms to prevent a future reoccurrence were often vague or generic and provided little detail or support to staff as to how to mitigate future risks.
- The provider did not always ensure incidents were reported internally or to the relevant external authorities/bodies. We found incidents were not reviewed and thoroughly investigated by competent staff. Incidents were also not monitored to make sure appropriate action was taken to address the situation, prevent future reoccurrences and make improvements as a result. Staff were not all competent in raising incidents. We reviewed the provider's safeguarding tracker/audit and identified between 31 August 2017 and 3 November 2017 there were at least ten instances where a safeguarding referral should have been raised but were not.
- The provider did not share the outcome of investigations into incidents with the young people who were involved. Where the provider had made referrals to the local authority safeguarding team, outcomes were not sought from the referral. We spoke with nine young people during the inspection who told us of multiple incidents where they were not aware of any external authority involvement (such as the police or local safeguarding team). We were told staff did not feedback this information and we found no evidence in the care records to evidence any discussion had taken place. This was contrary to the provider's policy which states "all staff will keep accurate, contemporaneous records in the service users' clinical record. All entries should provide factual information, timing of events and reasoning behind the decisions made. When making contact with staff or other agencies, any questions asked or information given should be recorded".
- We found the provider did not always support young people following incidents. When young people had made allegations of abuse, or actual abuse, there was no evidence the required support was received by young people. This was contrary to the providers policy whereby staff should speak with young people following an incident to seek their views and decide collaboratively how best to support the young person.
- During our review of the wards incident logs we found a high level of incidents that had not been reported to the correct external agencies, including the Care Quality Commission.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Skilled staff to deliver care

Child and adolescent mental health wards

- We found staff were not always competent, skilled and experienced to provide care and treatment to young people. We found evidence of a number of incidents that staff should have been able to manage but had required police attendance at the wards for assistance and support. The wards were often reliant on police intervention to assist in the management of incidents. This had been raised to the provider by the police as a concern, however, no appropriate action had been taken to train staff in how to manage repeated incidents to prevent their future reoccurrence and need for police assistance.
- We found staff were not supported in their individual responsibilities to prevent, identify and report abuse. This including making referrals to the local authority safeguarding team. The clinical services manager or social worker made all referrals to the safeguarding team. This was contrary to the provider's policy which stated "all members of staff should be supported in making a referral to social care". Staff were not supported, skilled or competent to do this.

Multi-disciplinary and inter-agency team work

- We found handovers between staff, daily meetings and multidisciplinary team meetings were failing to identify where incidents or safeguarding issues had happened. Where incidents were discussed, no action was taken to safeguard young people and prevent reoccurrence.
- Communication between the provider and external agencies was not taking place appropriately. We found a number of incidents that were reportable to external agencies that had not been referred.

Are child and adolescent mental health wards well-led?

Good Governance

- We found the provider did not operate effective audit and governance systems and processes to make sure they assessed and monitored the service at all times. This was not undertaken in response to the changing needs of young people on the wards. For example, there was no robust system in place to reduce the risks associated to the health safety and/or welfare of young people on Knole ward and Littleoaks. This included repeated incidents on the wards that were not identified, monitored or learned from.
- We found the provider did not have an effective system in place to monitor safeguarding. The provider did have a safeguarding tracker/audit where information such as the incident type, date and if a referral had been made to the local authority and the outcome should have been logged, monitored and recorded. However, the information in the tracker/audit was not up to date and was not accurate. We found there were multiple pieces of information missing. This included if referrals had been made to the local authority safeguarding team and if any actions taken as a result. The tracker/audit was not being regularly reviewed by staff with the appropriate skills and competence. We found the tracker/audit was not fit for purpose, as it did not identify where quality or safety had been compromised and therefore could not be responded to or addressed.
- We found a high number of incidents, which the provider was required to escalate to both the local authority safeguarding team and the Care Quality Commission that had not been reported. There was no evidence that these incidents had been escalated within the organisation and there was no oversight or management at hospital level.
- We found the provider did not maintain complete, accurate and up to date records when an incident had occurred. The provider's policy, 'Safeguarding children and young people', stated young people should have a preventative supervision plan in place if required. We found there were young people who should have had such a plan in place but did not. We found the quality of incident forms to be variable. Most incident forms had information missing and were incomplete. The forms should have been reviewed and signed off by the ward manager but we found this was not happening in every instance.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure young people's risk assessments and risk management plans are updated and reviewed following incidents.
- The provider must ensure all incidents are monitored, investigated, and appropriate action taken. Incident forms must be completed fully and accurately.
- The provider must ensure all incidents are reported internally and to the relevant external bodies/ authorities.
- The provider must ensure effective processes are put in place to support partnership working and communication with other professionals both internally and with external authorities/bodies.
- The provider must ensure they share the outcome of investigations into incidents with the people who were involved.
- The provider must ensure young people are supported following incidents as per the provider's policy.
- The provider must ensure that analysis of all incident trends is undertaken to support staff learning and reduce to the risk of future reoccurrence.
- The provider must ensure all staff are trained, skilled and competent to identify abuse and raise a safeguarding alert and to manage incidents on the wards safely.
- The provider must operate effective audit and governance systems and processes to make sure they continually assess and monitor the service at all times.

Action the provider SHOULD take to improve

- The provider should ensure handovers and daily meetings between staff identify all risks, incidents and safeguarding concerns and appropriate action is taken.
- The provider should ensure environmental risk assessments are kept up to date and identify all risks with clear actions set how these will be remedied or mitigated.
- The provider should ensure closed circuit television is working at all times and the control measures in place support this.

This section is primarily information for the provider

Enforcement actions

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 Risk assessments relating to the health, safety and/or welfare of young people were not always completed or regularly reviewed. Risk management plans were not updated following incidents. Incidents were not reported internally or externally as required. Incidents were not reviewed or investigated thoroughly. Action was not taken to prevent further occurrences; Staff were not skilled, competent or experienced to provide safe care and treatment. Regulation 12 (1)(2)(a)(b)(c)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have and/or implement robust procedures and processes to make sure young people were protected from abuse or risk of abuse. Staff were not supported to prevent, identify and report abuse. Appropriate action was not always taken as soon as they were alerted to suspected, alleged or actual abuse, or the risk of abuse. Incidents were not fully investigated. Regulation 13 (1)(2)(3)(6)(b)(d)

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

This section is primarily information for the provider

Enforcement actions

The provider did not operate effective audit and governance systems and/or processes to make sure they assessed and monitored the service at all times. Because of this, risks that should have been identified were not monitored and appropriate action was not taken. Following an incident, records were not completed, accurate or kept up to date.

Regulation 17 (1)(2)(a)(b)(c)(f)