Cygnet Health Care Limited

Cygnet Hospital Kewstoke

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	Good
Are services safe?	Requires Improvement

Summary of findings

Overall summary

Cygnet Hospital Kewstoke is an independent mental health hospital near Weston-super-Mare in Somerset. It provides a range of specialist mental health services. This can include people detained under the Mental Health Act, those who use their behaviours to communicate their frustrations and anxiety, and those with long-term mental illness.

This was an unannounced focused inspection following a tragic incident in which a patient died on Sandford ward that has resulted in a range of interventions and investigations from external agencies and stakeholders; these are ongoing.

Our inspection focused on whether patient were safe and so we only looked at the key question 'are services safe'.

Our rating of the Safe key question went down. We rated it as requires improvement because:

- Risk management plans were not person centred and contained generic statements.
- The service did not always have enough nursing and medical staff who knew the patients. Staffing levels and skill-mix were not always appropriate to meet patient's needs.
- Patients were routinely missing out on section 17 leave. Poor staffing levels meant patients sometimes had their leave cancelled or postponed.
- The service had complicated internal processes when escalating safeguarding concerns. Internal processes meant there were delays making referrals to external organisations.

However:

- All wards environments were safe, well equipped, well furnished, and fit for purpose.
- Staff received basic training to keep people safe from avoidable harm.
- Staff had easy access to clinical information whether paper-based or electronic.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good	Cygnet Hospital Kewstoke is an independent mental health hospital near Weston-super-Mare in Somerset. It provides a range of specialist mental health services. This can include people detained under the Mental Health Act, those who use their behaviours to communicate their frustrations and anxiety, and those with long-term mental illness.This was an unannounced focused inspection following a tragic incident in which a patient died on Sandford ward that has resulted in a range of interventions and investigations from external agencies and stakeholders; these are ongoing. Our inspection focused on whether patient were safe and so we only looked at the key question 'are services safe'. Our rating of the Safe key question went down. We rated it as requires improvement because: • Risk management plans were not person centred and contained generic statements. • The service did not always have enough nursing and medical staff who knew the patients. Staffing levels and skill-mix were not always appropriate to meet patient's needs. • Patients were routinely missing out on section 17 leave. Poor staffing levels meant patients sometimes had their leave cancelled or postponed. • The service had complicated internal processes when escalating safeguarding concerns. Internal processes meant there were delays making referrals to external organisations. However: • All wards environments were safe, well equipped, well furnished, and fit for purpose. • Staff received basic training to keep people safe from avoidable harm. • Staff had easy access to clinical information whether paper-based or electronic.

Summary of findings

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Summary of this inspection

Background to Cygnet Hospital Kewstoke

Cygnet Hospital Kewstoke is an independent mental health hospital near Weston super-mare in Somerset, providing a range of specialist mental health services. This can include people detained under the Mental Health Act, those who use behaviours to communicate their frustrations and anxiety, and those with long-term mental illness.

There are five wards within the hospital at the time of inspection. Nash ward is a male psychiatric intensive care inpatient ward with 12 beds. Sandford ward is a female acute inpatient ward with 16 beds. Milton ward is a female low secure inpatient ward with 16 beds. Knightstone ward is for females with a diagnosis of personality disorder and has 15 beds. The Lodge is a high dependency inpatient rehabilitation service situated in a separate building on the grounds and has a 12 bed capacity.

At the time of this inspection the hospital had a registered manager in post. The hospital is registered to provide two regulated activities; treatment of disease, disorder or injury and assessment or medical treatment of persons detained under the Mental Health Act 1983.

The service was last inspected in May 2019 and was awarded a rating of good across all wards and had no outstanding recommendations or requirements.

This was an unannounced focused inspection. We considered information from notifications submitted by the provider as well as information received from stakeholders and people who use the service. There have been specific concerns around staffing and the impact this was having on care provided. A recent tragic incident in which a patient died on Sandford ward has resulted in a range of interventions and investigations from external agencies and stakeholders; these are ongoing. Our inspection activity focused on provisions in place to keep people who use the service safe. This was an unannounced focused inspection on our key question of safe.

A follow up visit was undertaken on 3rd October by a CQC pharmacist specialist to review initial concerns around the management and use of medications. At this time there was no registered manager in post. However, an application has now been submitted to fulfil this position by the current acting manager.

How we carried out this inspection

As this was a focused inspection, we only looked at the key lines of enquiry in the safe domain. We asked the following question of the service:

- Is it safe?

Before the inspection visit, we reviewed information that we hold about the location, including the previous inspection report, ongoing monitoring information and information from stakeholders.

During our inspection visits, the inspection team:

- visited Nash and Sandford wards
- reviewed 18 care and treatment records
- spoke with 13 staff members including nurses, support workers, safeguarding lead and managers.

Summary of this inspection

- reviewed medication administration records
- reviewed incident and safeguarding records
- reviewed 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.

Action the service MUST take to improve:

- The service must ensure that staffing levels are adequate to respond to incidents and skill mix of staff meet the needs of all patients and keep them safe. Regulation 18(1)
- The service must ensure care plans are comprehensive, cover the safe management of underlying physical health conditions and physical health monitoring is documented robustly. Regulation 9 (1b)
- The service must ensure patients are routinely receiving section 17 leave and 1 to 1 sessions with staff in accordance with the therapeutic offer to patients. Regulation 9 (3b) (c)(d)(f)

Action the service SHOULD take to improve:

- The service should ensure that escalation and referral of safeguarding concerns are not delayed due to internal processes.
- The service should ensure staffing levels allow staff to take their allotted breaks.
- The service should consider staffing arrangements to ensure adequate support is available across wards where called for.
- The service should ensure any personal contact information is removed from communal areas.
- The service should ensure care records clearly document appropriate usage of rapid tranquillisation for each patient.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Not inspected	Not inspected	Not inspected	Not inspected	Good
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Not inspected	Good

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

Good

Safe

Requires Improvement

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

Requires Improvement

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

Safe and clean care environments

All wards were safe, well equipped, well furnished, and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. For example, en-suite facilities were free from ligature anchor points with door handle and hinge fixtures that prevented anchor points being possible. Observation panels were present on all bedroom doors.

Staff could observe patients in all parts of the wards. Where this was not possible, parabolic mirrors were placed in bedrooms and communal areas so staff could view areas not possible to observe by direct line of sight. The seclusion suite in Nash ward utilised a CCTV system to view hard to observe areas from outside of the room.

The ward complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems. Bedrooms had alarms to request staff support and all staff carried alarms to request support in the event of an emergency.

Maintenance, cleanliness and infection control

Sandford ward areas were clean, well maintained, well-furnished and fit for purpose. The ward was brightly painted with pictures and information boards.

Nash ward areas were maintained, furnished and fit for purpose. There was a housekeeping team responsible for cleaning ward areas. However, there were areas of Nash ward that were not clean. Staff told us there were occasionally issues when patients did not want housekeeping staff in their bedroom areas to clean.

Communal areas on both wards included: lounges with TV's, quiet lounges, access to the terrace at all times and a separate exit to the main reception. This was used by informal patients to leave the ward and required staff to open it upon request. We observed this to be actioned quickly when required.

There were communal areas on both wards that required general maintenance. For example, we saw wall art stickers used to enhance the environment had been damaged and patients had written on the walls, this included personal contact information that had not been removed.

Staff followed infection control policy, including handwashing.

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

Good

Seclusion room

The seclusion room situation on Nash ward allowed observation of all areas of the room by utilising CCTV to view all areas and enable two-way communication. It had a separate toilet and shower room, a clock and utilised adjustable mood lighting to assist with de-escalation.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. During our visit, Ashtons pharmacy were conducting a regular audit and discussed findings with staff. Physical health monitoring equipment was appropriately calibrated and safety checked.

Staff checked, maintained, and cleaned equipment. Signage was placed in areas to remind staff where vital clinical equipment was stored. For example, ligature cutters were clearly displayed and signage also helped direct staff to where equipment was stored that would be required in the event of an emergency.

Safe staffing

The service did not always have enough nursing staff who knew the patients. Staff received basic training to keep people safe from avoidable harm.

Nursing staff

The service had high vacancy rates for nursing and support staff. At the time of our inspection there were 32 vacant support worker posts and 12 registered mental health nurse (RMN) vacant posts. However, managers told us 10 RMN's had recently accepted offers of employment but had not yet started in post.

The service had high rates of bank and agency staff. Staff told us it was common for a majority of ward staff on duty, to be bank or agency staff.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The service accessed an IT program that improved the fulfilment of shift vacancies. Qualifications, experience and suitability to work prior to bank and agency staff beginning their shift were accessible and required approval to managers prior to starting a shift.

Managers calculated the number and grade of staff for each shift using a standard matrix. Staff gave us feedback on the lack of consideration from managers to increasing staffing levels when patient's level of needs escalated. They said this led to inappropriate staffing levels to meet the needs of all patients on the wards.

Patients did not have regular one to one sessions with nurses. Staff told us this did not happen due to unmanageable workloads that prevented them from spending time with patients.

Staff told us patients were routinely missing out on accompanied and section 17 leave. We were told patients were asked to delay leave and sometimes needed to cancel leave. This contributed to patients becoming agitated and communicating their frustration using behaviour that placed them and others at risk of harm.

Staff were not always able to take breaks. This increased the potential for staff becoming fatigued and unable to fully meet the needs of people they were providing care and treatment to.

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

Good

The service did not always have enough staff on each shift to carry out any physical interventions safely. Staff responded to requests for support from other wards via the use of 2-way radios. However, staff told us there were times when some wards were not able to provide support when they did not have a full staff compliment on their own ward.

Staff did not always share key information to keep patients safe when handing over their care to others. Care records were not descriptive with behaviour management strategies. For example, rapid tranquillisation care plans did not outline the first line medication to be used or recommended dosages. Furthermore, patients with underlying physical health conditions did not have specific plans in place to address them.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. However, there were vacancies for two permanent consultant roles that were currently being covered by a locum and a doctor from another ward.

Managers could call locums when they needed additional medical cover and they had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Compliance for completed training was over 96% at the time of our visit. Training was offered via online resources and through face to face sessions. For example, prevention and management of violence and aggression (PMVA) was undertaken through face to face sessions with the 'in house' PMVA instructor.

The mandatory training programme was comprehensive and met the needs of patients and staff. Training units included safeguarding, equality and diversity, and PMVA training.

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

Assessing and managing risk to patients and staff

Staff assessed risks to patients and themselves. Staff did not always use restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Staff used the providers standard risk assessment tool. All patients had a risk assessment and risks were documented. This was completed on admission and reviewed regularly, including after any incident.

Risk management plans were not person centred and contained generic statements. For example, a care record we reviewed stated 'utilise diversion', this did not include specific known working strategies and was open to interpretation.

Management of patient risk

Staff knew about any risks to each patient. However, care records did not include detailed information on successful and unsuccessful interventions that were important for each patient. Care records used generic statements on managing risk that were used across records we reviewed.

Staff identified and responded to any changes in risks to, or posed by, patients. We saw interventions were altered for patients following incidents. For example, interventions such as increased observations, increased staff ratio and reviewing their suitability to remain at the hospital.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The provider had a search policy that staff adhered to. On admission, patients were searched to check for items deemed to pose a risk to themselves and others, these items were stored within the security room on the ward until the identified risk was deemed no longer present or upon hospital discharge or transfer.

Use of restrictive interventions

Staff did not always make every attempt to avoid using restraint by using de-escalation techniques. Care records we reviewed showed the use of rapid tranquillisation on patients was not considered as a last resort to prevent patients causing serious harm to themselves or others. We saw evidence that rapid tranquillisation could be used when 'refusing oral medication' or 'to allow a person to make an informed decision'. However, at the time of our inspection, this had not been used under these circumstances.

Staff participated in the provider's restrictive interventions reduction programme. Staff told us managers encouraged them to use least restrictive interventions with patients. However, four of the care records reviewed did not clearly state use of de-escalation strategies within the prevention and management of violence and aggression PMVA were to be used prior to using medical methods.

Staff did not always follow NICE guidance when using rapid tranquillisation. Strategies noted in some records directed staff to use rapid tranquillisation in situations where there was not a risk of serious harm. For example, we saw direction to use rapid tranquillisation on a patient with a history of heart failure when oral medication was refused, there was no indication within the care record that pre-existing physical health problems were considered.

When a patient was placed in seclusion, staff kept clear records and sought to end the time in seclusion as short as possible.

Safeguarding

Staff understood how to protect patients from abuse the service worked with other agencies to do so. Staff had training on how to recognise and report abuse.

Staff received training on how to recognise abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. All Staff met their mandatory training requirements.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults at risk of or suffering harm. For example, care records recorded specific harmful behaviours. However, strategies to manage these behaviours were not comprehensive, they did not always detail individual successful and unsuccessful interventions that were person centred.

Staff knew how to make a safeguarding referral. They knew who to inform if they had concerns. However, staff told us the process for escalating concerns and completing relevant forms was confusing. They told us they did not receive any official training in relation to internal safeguarding processes or received adequate feedback to enable them to meet subjective expectations of the providers safeguarding lead. Information we reviewed showed there were delays in sharing safeguarding concerns with external agencies due to internal processes not working effectively. This meant there were times when safeguarding concerns were not acted upon within a timely manner to protect people who use the service. Senior leaders told us they were already aware of these issues and a plan was underway to ensure these processes were streamlined and issues causing delays in notifying external agencies were resolved.

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

Good

Staff access to essential information

Staff had easy access to clinical information whether paper-based or electronic.

Staff could access patient notes. Patient notes we reviewed contained information about meals eaten, medicines compliance, general mood and nursing observations. Where there was occupational therapist input, this was documented.

Managers were able to provide access to IT systems for agency staff

When patients 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 patient's mental and physical health.

Staff reviewed each patient's medicines regularly and provided advice to patients about their medicines. Patients had care plans that described the use of medicines prescribed to be given when required. These care plans indicated that oral medicines should be used first, before consideration of intra-muscular medicines. Prescription and administration records showed that staff were following these care plans. Where staff administered 'as required' medicines staff carried out regular observations to ensure the patient was safe.

Staff completed medicines records accurately and kept them up-to-date. Patients allergy status was included on prescription charts. Records included an assessment of the risk of venous thromboembolism.

Staff stored and managed all medicines and prescribing documents safely.

Staff learned from safety alerts and incidents to improve practice. In response to prescribing incidents, doctors and nurses had attended medicines management training and updates. An audit of clozapine prescribing had been completed

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. From the prescription charts reviewed, no-one had received rapid tranquillisation. When oral medicines were used to control a patient's agitation or distress, this was reviewed at the daily clinical governance meeting to see what could be done differently.

Medicines were prescribed with clear therapeutic aims. Local changes to the prescribing policy had been made to improve consultant oversight and to make sure patients had appropriate test results before new medicines were prescribed.

Staff regularly reviewed the effects of medicines on each patient's mental and physical health in line with guidance from the National Institute of Health and Care Excellence.

Track record on safety

There had been two unexpected deaths on Sandford ward in 2022.

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

Good

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of medication prescribing and administration.

At the time of the inspection, partner agencies, such as the coroners office and the police, were investigating the cause of deaths.

On the 1st April 2015 CQC assumed enforcement responsibility for health and safety related serious incidents for patients in England. Depending on the outcomes of these investigations, we may consider if further regulatory action is needed..

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and followed the provider's policy. Staff reported incidents using an electronic system, which alerted managers when incident report forms were submitted. Incidents were reported appropriately, and serious incidents had been notified to CQC and other agencies, For example, the local authorities and Health and Safety Executive, where appropriate.

Managers shared lessons learned with staff, a lessons learned folder was located in the staff rest room. This contained lessons learned from incidents, audits and complaints. The service sent a weekly brief email to staff providing them with up-to-date news within the hospital, such as policy changes, COVID updates and also lessons learned.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Documentation we reviewed showed this.

Managers debriefed and supported staff after serious incidents. Referrals were also made to trained Sustaining Resilience at Work (StRaW) and Trauma Risk Management (TRiM) practitioners within the service for further support. This process was implemented following a recent catastrophic incident on Sandford ward.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Documentation we reviewed showed clear escalation to investigation and final outcome

Staff received feedback from investigation of incidents, both internal and external to the service. For example, a patient safety incident regarding an imposter agency worker undertaking the role of a qualified registered mental health nurse was shared by NHS England. As part of a Cygnet provider wide learning, additional checks were implemented to ensure agency workers identity were fully checked prior to starting a shift.

There was evidence that changes had been made as a result of feedback. Following an incident earlier in the year, the registered manager implemented regular immediate life support drills on the wards. This was undertaken due to feedback that staff did not feel as confident as they hoped following an incident. As a result, staff reported feeling more confident undertaking this duty when required.

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 18 HSCA (RA) Regulations 2014 Staffing Staffing levels were not always adequate enough to respond to incidents and the skill mix of staff was not sufficient to meet the needs of patients.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care plans were not comprehensive and did not specifically outline the safe management of patients with underlying physical health conditions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Patients were not routinely receiving section 17 leave or having 1 to 1 sessions with staff.