Cygnet Hospital Bury

Quality Report

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

Overall summary

We visited Cygnet Bury Hospital unannounced to conduct a focused inspection within the child and adolescent services. This was due to an increase in incidents being reported to CQC and information from whistleblowers. We looked at the safe domain as concerns related to staff and medicines.

We also reviewed one requirement notice, which related to the child and adolescent service from the last inspection in February 2015. When we last visited the CAMHS we found that staff were not always carrying out physical health checks on young people following the use of rapid tranquillisation (rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them).

The inspection team were assured that this requirement notice had been met. We reviewed rapid tranquillisation (RT) records and saw evidence that staff had completed the practice audit tool after each use of RT. The ward managers received weekly summaries of the use of restraint, RT, and seclusion. We reviewed medicine management committee minutes where the senior team at the hospital reviewed the use of RT. Night quality managers reviewed the RT forms to ensure physical observations had taken place and provided a summary for ward managers daily.

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Background to Cygnet Hospital Bury

Cygnet Hospital Bury provides child and adolescent mental health (CAMHS) Tier 4 services to young people aged between 11 and 18. Tier 4 inpatient services deliver specialist care to children and young people who have severe and/or complex mental health needs that cannot be adequately treated and managed safely by community CAMHS. Some of the young people present behaviour that challenges and may present a risk to themselves or others.

There are five CAMHS wards within the hospital, four are psychiatric intensive care units (PICU) for young people and one ward is a general acute ward for young people.

- Mulberry Ward is a mixed PICU with eight beds.
- Blueberry Ward is a mixed PICU with eight beds.
- Primrose Ward is a female PICU with eight beds.
- Buttercup Ward is a mixed PICU with eight beds.
- Wizard House is a mixed general ward with 10 beds.

All of the wards are for young people who require emergency admission due to their mental health needs. Young people may progress to Wizard house from one of the PICUs as part of their treatment pathway. Wizard House also accept direct referrals.

The regulated activities provided are:

- Treatment of disease, disorder or injury
- Nursing care
- Diagnostic and screening procedures
- Assessment or medical treatment for persons detained under the Mental Health Act 1983

There is currently no registered manager at the location however, the hospital director has applied to become the registered manager and is going through the application process.

CQC last inspected the hospital in February 2015 and there were four requirement notices issued to the hospital following the inspection, of which only one specifically related only to CAMHS.

This inspection was unannounced to conduct a focused inspection within the child and adolescent services. This was due to the hospital reporting an increase in incidents to CQC and information from whistleblowers. We looked at the safe domain as concerns related to staff and medicines.

During this inspection, we reviewed the requirement notice that related directly to CAMHS. When we last visited the CAMHS we found that staff were not always carrying out physical health checks on young people following the use of rapid tranquillisation (rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them).

The inspection team were assured that this requirement notice had been met. We reviewed rapid tranquillisation (RT) records and saw evidence that staff had completed the practice audit tool after each use of RT. The ward managers received weekly summaries of the use of restraint, RT, and seclusion. We reviewed medicine management committee minutes where the senior team at the hospital reviewed the use of RT. Night quality managers reviewed the RT forms to ensure physical observations had taken place and provided a summary for ward managers daily.

Our inspection team

Team leader: Sarah Heaton

The team that inspected the service comprised a CQC inspection manager, three CQC inspectors, a Mental Health Act reviewer and a specialist advisor with experience of child and adolescent services.

Summary of this inspection

Why we carried out this inspection

We inspected this service as a focused inspection within the child and adolescent services. This was due to an increase in incidents being reported to CQC and information from whistleblowers.

How we carried out this inspection

The inspection was a focused inspection and asked the question of the service:

- Is it safe?

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

During the inspection visit, the inspection team:

- visited all five wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with five patients who were using the service;
- spoke with the hospital director, clinical services manager, medical director and managers for each of the wards;
- spoke with 19 other staff members; including doctors, nurses, support workers, and the lead for training in the management of violence and aggression;
- attended and observed two morning meetings;
- reviewed seven care and treatment records of patients;
- reviewed 41 prescription cards;
- carried out a specific check of the medication management in relation to rapid tranquillisation;
- completed a review of seclusion procedures and documentation;
- 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 to five young people who were patients on the psychiatric intensive care units.

All young people we spoke to felt the use of holds and physical intervention was appropriate at the time of incidents to ensure that staff kept them safe. Young people reported they had the opportunity to talk about the incident afterwards to try to identify triggers and ways to reduce or avoid a recurrence.

Young people found the stages system of red, amber and green, which the hospital linked to their behaviour and whether they had been involved in incidents to be confusing and potentially punitive.

The young people we spoke to reported being involved in their care plans and that staff asked them what they found helpful in supporting them.

Mostly, young people felt safe on the ward; however, they told us that it could be scary when there were other young people presenting challenges. They reported having limited space to go to when they wanted to avoid an incident or an unsettled time on the ward.

Young people reported the staff were caring and supportive however, it could be difficult to have the opportunity to talk to staff as they were busy supporting other young people.

Detailed findings from this inspection

Child and adolescent mental health wards

Safe

Summary of findings

We did not rate this service as CQC had not previously rated them and it was a focussed inspection. We found the following areas of good practice, the provider:

- maintained a safe and clean environment for young people
- had current risk assessment documentation in place for patients which was regularly reviewed
- managed medicines well in relation to storage, prescriptions, pharmacy and stock arrangements
- completed physical health checks on young people following the use of rapid tranquillisation
- completed accurate records of seclusion and records confirmed that seclusion was necessary, regularly reviewed and terminated at the earliest opportunity
- provided safe staffing levels, with the use of regular agency staff to provide consistency
- identified where there were high levels of restraint used, and planned actions to reduce use
- had attendance levels of mandatory training above 80%

However, we found the following issues that need to improve:

- the observation policy and seclusion policy had not been reviewed and did not reflect the current Code of Practice
- staff on the wards were not aware of the location of the ligature audit and their role in relation to the audit
- the seclusion facilities required updating to meet the MHA code of practice and to protect young people's privacy and dignity
- medicines were dispensed via hatches to young people in communal areas
- staff on the wards were not aware of learning from incidents.

Actions the provider must take:

- The provider must review the seclusion and observation policy to ensure they adhere to the MHA code of practice.
- The provider must ensure that patients privacy and dignity are protected within the seclusion rooms when needing to use the toilet or shower facilities.

Child and adolescent mental health wards

Are child and adolescent mental health wards safe?

Safe and clean environment

We visited all five ward areas. PICU wards all had an open lounge area with bedroom corridors and other rooms leading off, for example, quiet rooms. Staff facilitating the tour described the quiet rooms as ordinarily open for young people to access but if there were identified risks to rooms being accessible staff may lock them. At the time of this inspection, staff had locked all quiet rooms on the PICU wards and young people required staff to allow access. On several wards, there were quiet rooms, which only contained a settee and staff reported using these rooms for de-escalation if patients were disturbed. Wizard ward was over two levels, split between a ground floor and first floor level and staff performed frequent checks around both levels. On all wards, there were staff undertaking regular zonal and ward observation checks and CCTV monitoring was in place in all communal areas of wards.

Ward managers completed ligature audits on a monthly basis. Ward managers could locate the ligature audits however, other nursing staff were not aware of the location of the audits and their response in relation to the audits. Young people in the PICU wards did not have unsupervised access to areas with ligature points or safety risks, for example, serveries or laundry rooms. Ward bathrooms had flush taps and sanitary fittings. Items that young people could use for self-harm, for example, razors or glass toiletries, were risk assessed and staff supervised use in most cases. When not in use staff locked these items in patients' own lockers.

All wards had two lounges where there could be gender separation, bedrooms were ensuite and this complies with the guidance on mixed sex accommodation for mental health services.

Emergency equipment was stored in grab bags so that it was available immediately in an emergency. Nursing staff checked this on a daily basis on all wards. Emergency medication boxes were available in each clinic if needed. Ligature cutters had previously been stored in the clinic but due to difficulties accessing these when needed, the hospital had reviewed this. Ligature cutters (and wire cutters) were stored in the ward office on all wards, and several wards had additional sets of these located in locked storage on the bedroom corridors. This meant these were readily accessible if needed in an emergency and additional sets meant that there would be equipment available if staff had used one of the sets. The hospital had a system in place to replace these if used.

There were two seclusion rooms; the hospital had decommissioned three seclusion rooms since our last visit, due to the safety of the rooms and non-compliance with the Mental Health Act code of practice. The two rooms remaining allowed clear observation with the use of parabolic mirrors. There was a fault with the intercom in the seclusion room at Primrose ward; staff had to communicate to the young person via the observation panel. Staff controlled the lighting and heating externally and the young person had sight of a clock to orientate to time. However, toilet and shower facilities were within the rooms with no protection for patient's privacy and dignity.

Staff told us that they would move away from the window when patients were using the toilet or shower, however, there was no written procedure for staff to follow. CQC had identified this at the last inspection, along with concerns about the cleanliness of the seclusion rooms, and a requirement notice issued. There was an agreed plan of works in place, and the provider was in the process of tendering for the work to modernise the seclusion facilities, create an extra care area and a sensory area to provide more opportunities and areas for young people to deescalate. The cleaning actions that the hospital had created following the last inspection included weekly environmental checks of the facilities and cleaning checklists after each episode of seclusion. Records reviewed showed staff were adhering to the cleaning procedures for seclusion rooms. The seclusion rooms were clean. The seclusion policy staff were following dated March 2014 did not adhere to the current MHA code of practice.

Wards were clean and tidy, with cleaning staff working during the day on each of the ward areas. There were cleaning schedules in place, which staff adhered to. Furnishings and furniture were in good condition and well maintained.

Handwashing sinks were available in kitchen and clinic areas. Infection prevention equipment was available in all the clinic rooms visited.

Child and adolescent mental health wards

We inspected clinic rooms on each of the wards. Clinic rooms were clean and tidy. There was adequate locked storage for medicines and space for storing equipment. There were processes for removing unused and unneeded medication supplies. Staff monitored clinic room and fridge temperatures on a daily basis. The fridge in the clinic for Primrose and Buttercup ward was not maintaining a low enough temperature. The hospital had transferred the medication to another ward's fridge until the arrival of a new fridge.

The clinic room on Wizard ward was the only area with an examination couch. Staff on the other four wards would escort patients to the GP clinic room to complete examinations and regular physical observations. There was equipment available on each ward to undertake routine physical observations and staff checked this on a daily basis and cleaned it regularly.

Wizard ward was also the only area where patients had medication dispensed in the clinic and staff were able to talk privately with them about their treatment as they were dispensing. On the four other clinical areas, staff dispensed medication via a small hatch. The hatches were all located in communal areas, either day or dining areas. This meant young people could not discuss their treatment privately and staff could not fully assure themselves that patients had taken their medicines, given the restricted view they had of the person. Additionally, on Primrose and Buttercup wards, there was a small clinic shared by both wards. A hatch for Primrose ward was on the wall opposite the hatch for Buttercup ward. There were local procedures to prevent these being open at the same time due to concerns about contraband or young people passing medicines from one person to another. Therefore, there may be delays in medication administration for young people if the other ward staff were already dispensing medication. Additionally, this clinic room was small and narrow for two groups of staff to use and staff accessed it via one ward's nursing office only.

The other concern about the use of hatches was that on Primrose and Mulberry wards it was evident that young people used this as a way to interact with staff, by knocking on the hatch if it was clear that staff were within the clinic areas. We noted young people having conversations about their progress and staff passing phone numbers and written information through these on several occasions. This did not promote patient's dignity.

We reviewed all 41 prescription charts within the service. The prescription charts were up-to-date and clearly presented to show the treatment people had received. The hospital had a system of codes to use to record the omission of medication. The relevant legal authorities for treatment were in place and monitored by the pharmacist and nursing staff. Staff used a side effects tool regularly to help ensure that anti-psychotic side effects were recognised and appropriate action taken.

Ten young people were being treated under urgent treatment authorisations (Section 62), nine of these due to the expiry of the initial three-month treatment period and awaiting a second opinion approved doctor, and one awaiting a second opinion doctor where concerns had been identified about capacity to consent following a capacity assessment. One section 62 authorisation did not include all medication prescribed and this was immediately brought to the attention of staff. The prescriber had made the changes to treatment that day and staff had not administered the medication.

Staff completed capacity assessments in relation to treatment at admission and regularly after. Staff offered young people written information about medication and recorded treatment discussions in clinical records. When treatment differed from National Institute for Health and Care Excellence guidance, there was a clear rationale for this.

Where additional monitoring was required, we saw that staff had completed this, for example, in relation to lithium. All young people prescribed antipsychotic medication had care plans detailing the monitoring required and records confirmed staff were completing this.

Nursing staff had completed good quality physical health care plans where needed. The GP regularly reviewed young people with physical health conditions, for example, diabetes.

Staff used a personal alarm system to summon assistance if required. Staff responded to emergency alarm calls from each of the ward areas.

Safe staffing

Staffing establishment levels were eight qualified staff for Mulberry, Blueberry, Buttercup and primrose. Wizard House had 10 qualified staff in their establishment levels. Across the CAMHS service, there were 23 vacancies for

qualified staff. The service was managing this by permanent staff working overtime or block booking agency staff. There were nine agency staff that the service had long-term booked, who knew the young people and provided consistency. The highest use of agency nursing staff was on Primrose ward, particularly at night with 749 hours covered by agency nurses from September to the end of November 2015. Review of three months of rotas showed that the same agency staff were working in the service.

Staffing establishment for unqualified staff was 24 at Primrose, Blueberry and Wizard House and 16 at Mulberry and Buttercup. There were no vacancies for unqualified staff.

Sickness rates for the last six months, from July to end of December 2015 across the service were an average of 3%.

There was a staffing matrix in place which all ward managers were familiar with. Ward managers used the matrix to calculate staffing figures for the number of young people on the ward. All staff had a minimum of two qualified staff in the matrix during the day and one at night. The number of support workers varied depending on the number of young people. The managers then incorporated the level of observations into the planning for numbers of staff required. Ward managers would offer permanent staff the overtime first then progress to regular bank staff and liaised with the staffing coordinator to source the additional staff required. Each shift a team leader who was a qualified nurse, took the role of having an overview of staffing numbers, staffing pressures and acuity on each of the CAMHS wards and deployed staff as required to meet need. Staff reported this worked well and seemed to meet the needs of the young people who required more intensive support.

Two staff and three young people that we spoke to reported that due to the increased observations of some young people, young people on general observations could not always access staff support to have meaningful one to one time to talk through issues or participate in an activity, for example playing a game. The National Minimum Standards for Psychiatric Intensive Care Units for Young People, September 2015 states that 'Each young person should be provided with the opportunity for one-to-one time with a member of staff every day.'

Feedback from staff and analysis of incidents showed that incidents increased in an evening. The governance team had highlighted the high use of restraint, rapid tranquillisation and seclusion on Primrose ward and had met in early January 2016 to discuss their findings. They explored restrictive practices, the need for functional assessments of young people's behaviour and the possibility of using the positive behaviour support approach, with agreed commitment to explore further and implement agreed actions including providing activities in the evening.

Rotas provided showed that on call medical staff were available and records confirmed that they attended out of hours when needed. The medical director was responsible for creating the on call rota for support from a psychiatrist out of hours; there was a first on call with staff grade support and then second on call support from a consultant psychiatrist.

All new staff completed a two-week induction, which included; fire safety, safeguarding adults and children, Mental Health Act, Risk Assessment, suicide prevention, escorted leave, mental health awareness and observation. New staff also completed MAPA (management of actual or potential aggression) and intermediate life support (ILS). New starters reported this made them feel able to undertake the role on wards. In addition to classroom training, the hospital allocated new staff a 'buddy' and they shadowed for a minimum of two shifts. The buddy was available to offer guidance and support and to be a role model.

Mandatory training attendance, including bank and block booked agency staff, at the time of inspection was:

- Risk assessment and management 88%
- MAPA 94%
- ILS 80%

Assessing and managing risk to patients and staff

Data provided by the hospital from July to the end of December 2015 in relation to managing violence and aggression included the number of incidents of seclusion: Buttercup 43, Blueberry 38, Mulberry 38, Primrose 36 and Wizard House 3.

The number of restraints across the service in the same time period was Primrose 635, Buttercup 513, Blueberry 407, Mulberry 239 and Wizard House 90. Staff recorded all

uses of holds, including guiding people away from an area, as restraint. The governance team had identified the high number of restraints on Primrose ward and had held a meeting on 8 January 2016 with the medical director, nurse consultant, ward manager and clinical team leader to try to understand the possible reasons and identify actions. One of the findings was the increase in the use of restraint in an evening and an action to try to reduce this was the aim of providing more activities in an evening. The meeting also identified the need to review the red, amber and green stages approach and increase the use of positive behaviour support plans with the inclusion of primary, secondary and tertiary strategies.

Of the incidents of restraint, the following were in the prone (face down) position: Buttercup 37, Mulberry 34, Primrose 30, Blueberry 18 and Wizard House 6. We reviewed several incident reports in relation to prone restraint and found the uses of prone restraint were for a minimal amount of time. The reasons for use of prone restraint were either that young people had usually placed themselves into the face down position and staff then turned the patient over to their back as soon as possible or for the administration of medication. The records of restraint were very thorough.

The hospital had also completed a least restrictive practice review. They had completed the report on 4 January 2016. The governance team had involved 29 young people and 32 staff and gathered anonymous feedback. Areas for improvement identified from the review included involving young people in the ongoing review of restrictive practices and ensuring that the hospital communicates clearly the restrictions and rationale behind these to young people.

We reviewed seven care records. All had a current risk assessment in place including a risk management plan. We could see evidence of reviews of the risk assessment and management plan following incidents. The hospital used the star risk assessment, which included formulation of risk, historical facts, triggers, current risks and risk management plan. There was a section for patient views, which some young people had completed, and others recorded that the patient declined. Staff documented all incidents related to the patient at the back of the risk assessment as an ongoing information log.

The hospital observation policy was due for review in August 2015; however, they were in the process of adopting the policies and procedures of the new provider, Cygnet. The policy described the level of observation and the use of zonal observations, which we observed staff following. The policy referred to historic National Institute for Health and Care Excellence (NICE) guidance, CG25 which has now been superseded by NG10, published in May 2015. It did not reflect the current MHA Code of Practice.

Young people we spoke to reported that staff used de-escalation techniques if they were becoming agitated or distressed including distraction and suggesting moving to a quieter area of the ward. When staff used restraint, the young people we spoke to reported staff had restrained them at occasions, which were appropriate, and they talked to staff after the event to try to understand the triggers.

We reviewed the use of rapid tranquillisation. The highest number of these occurred on Primrose ward. The governance team had identified this and a multidisciplinary group had met in early January 2016 to start to look at strategies to address this and other issues, including levels of restraint. Clinical records showed that de-escalation strategies were attempted and oral medication offered prior to use of rapid tranquillisation. The hospital had devised a rapid tranquillisation physical health monitoring tool and records reviewed showed staff were implementing this throughout the service. Nursing staff completed physical observations where possible following rapid tranquillisation for a minimum period of 90 minutes following any use of injectable medication. If young people refused or were agitated, nursing staff had recorded baseline respiratory rates and pulse rates where possible.

The medicines policy included a comprehensive section regarding rapid tranquillisation and children with prescribing recommendations that staff adhered to.

We reviewed the seclusion records and spoke to young people in seclusion. The format of the seclusion documents adhered to the MHA code of practice. Records reviewed confirmed that staff completed regular 15-minute observations with two hourly nursing reviews and four hourly medical reviews. There was a seclusion plan in place for a young person to protect their dignity, requiring the response team to be female. Records confirmed that seclusion was necessary, regularly reviewed and terminated at the earliest opportunity. The hospital had decommissioned three seclusion rooms since the last inspection. There were two rooms still in use, one of which was occupied by a patient from an adjoining ward. To

enable them to access the shower facilities in their room due to the shower fault in the seclusion room, they were escorted by four staff through the ward. If young people were present on the ward, they would have to move from communal areas to enable this to happen safely and protect the patient's dignity.

Staff we spoke to had a good understanding of safeguarding. They reported that they had attended training in safeguarding children and adolescents up to level 3.They provided examples of events that would constitute concern and what to do about reporting it or seeking further guidance. There were two leads for safeguarding, a consultant and a senior nurse. All staff we spoke to knew who the safeguarding leads were and understood their role in safeguarding. A social worker was available on site and provided specific help and assistance in formally reporting safeguarding to the Bury safeguarding team.

There were no controlled drugs being stored on site at the time of our visit. There was a local procedure for recordable drugs and these were stored within the controlled drugs cupboards and checked daily. There were no discrepancies in the registers for these.

On all wards, there was an up to date British National Formulary (BNF) and an up to date children's BNF.

Staff undertook a weekly audit of prescription cards and consent documentation. The pharmacist visited on a weekly basis and attended the monthly medicines management meeting. The pharmacist also completed a monthly audit across the service recording errors with consent paperwork, patient details, prescribing and administration errors. The governance team reviewed the monthly audits at the medicines management meetings.

Track record on safety

The hospital had reported two serious incidents within the service to CQC in the last six months. They completed an initial 72-hour review and a root cause analysis (RCA) for one of the incidents, in relation to one of the seclusion rooms. The analysis identified four actions following the RCA, which we reviewed at the inspection. Staff told us and records confirmed that the MAPA training had been enhanced to ensure staff understood how to safely exit the seclusion room. The seclusion room where the serious incident occurred had been decommissioned. Records confirmed that contact with the young person's home team had improved following incidents. The only action not completed was the review of the seclusion policy to include the safe exit of the seclusion room; however, the hospitals timescale was to complete this action by the end of January 2016.

Senior managers reported the second serious incident to the Health and Safety Executive and the RCA was in progress. Staff involved in the incident reported that the hospital had been supportive following the incident, providing both formal and informal support including two debriefs one immediately after the incident and another several days later.

Reporting incidents and learning from when things go wrong

All staff we spoke to could identify types of incidents that required recording on the incident recording system, DATIX. Staff at all levels recorded incidents on to the system. In the event of a restraint, one team member had the responsibility of making detailed notes during the incident to ensure accurate recording on DATIX post incident.

The hospital records all incidents on their electronic incident reporting system including low levels holds, and guiding a person away from a certain area or difficult situation. Attendees of the patient safety committee reviewed the number and nature of incidents monthly with staff representatives from across the hospital. Young people told us and records confirmed that incidents were reviewed with them and possible triggers were explored.

All staff we spoke to reported that post incident, managers were supportive and fair. If there was a serious incident, senior managers and psychology staff attended wards to review the health and welfare of staff and offer group or individual support and debrief.

Ward managers we spoke to were aware of lessons learned following incidents and could provide examples, however, staff on the ward were not aware of any lessons learnt.

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 The seclusion rooms had a toilet and shower within the seclusion room. There was no system in place to ensure that patients could use these facilities in private which meant their privacy and dignity not being maintained. This was a breach of Regulation 10(1)(2)(a)

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 The seclusion policy in place was dated March 2014 and the observation policy was due for review in August 2015 which had not happened. Both policies had not been updated to reflect the most recent Mental Health Act Code of Practice. This meant that there was a risk that patients would not be cared for in line with the current guidance. This was a breach of Regulation17(1)