Cygnet Hospital Stevenage

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Overall summary

We did not rate this inspection. The ratings from the inspection which took place 14 to 16 May 2019 remain the same. This was a focused, unannounced inspection to follow up on specific concerns we had relating to the safe domain.

Following our inspection, we served a Notice of Decision because of the immediate concerns we had about the safety of patients. We told the provider they must not admit or readmit any further patients until further notice; they must submit a complete weekly log of the last seven days of incidents; they must undertake a complete, immediate and continuing review of all patients' risk assessments and care plans; they must undertake a complete and immediate review of all patient observation levels and they must carry out a weekly review of all medication errors and how the risk of the error being repeated is being addressed. We told the provider that they must provide CQC with an update relating to these issues on a weekly basis.

We found the following during our focussed inspection:

Summary of findings

- The service relied heavily on agency and bank staff to ensure safe staffing numbers on the wards. Overall, there was a 56% vacancy rate for qualified nurses and support workers.
- Staff were not consistently updating patient risk assessments following incidents of violence or self-harm. Overall, 43% of risk assessments had not been updated adequately following an incident.
- Staff had not reflected patient risks within patients care plans.
- We looked at 20 patient's observation records across wards. On most records the date of next observation review was incomplete, and we saw no evidence that reviews had taken place. Details on the front sheet showing levels of observation, reasons for enhanced observation and date of next review were missing on multiple dates.
- The provider internally reported 130 incidents of self-harm across wards within a two-month period. Of those 130 incidents of self-harm, many patients were being supported by enhanced observations. We could not be assured staff carrying out observations were doing so in accordance with policy.
- There was a high number of medication errors on Orchid ward. We could not be assured that managers had taken appropriate steps to monitor and investigate the number of discrepancies.
- Overall, 42% of incidents that were notifiable to CQC had not been submitted by the provider.

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	Requires improvement 	
Forensic inpatient or secure wards	Requires improvement 	

Summary of findings

Contents

Requires improvement

Cygnet Hospital Stevenage

Services we looked at:
Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure wards

Summary of this inspection

Background to Cygnet Hospital Stevenage

Cygnet Hospital Stevenage is part of the Cygnet Health Care group which was founded in 1988 and offers a range of services for individuals with mental health needs and learning disabilities within the UK.

Cygnet Hospital Stevenage opened in May 2006 and consists of six wards: two acute inpatient wards, two medium secure wards and two low secure wards.

Acute wards are Orchid ward, a 14 bedded female only ward and Chamberlain ward, a 14 bedded male only ward.

Forensic wards include Peplau ward, a 14 bedded male only medium-secure ward, Pattison ward, a 14 bedded female only medium-secure ward, Tiffany ward, a 15 bedded female only low-secure ward and Saunders ward, a 15 bedded male only low-secure ward. At the time of inspection 71 patients were receiving care and treatment.

At the time of inspection, there was a nominated individual in post. A new hospital manager had been appointed who was undergoing checks to become the registered manager. Cygnet Hospital Stevenage is registered to carry out the following regulated activities:

- Treatment of disease, disorder or injury.
- Assessment or medical treatment for persons detained under the Mental Health Act 1983.

At the last inspection we rated Cygnet Hospital Stevenage as requires improvement and issued the following requirement notices:

Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment: The provider had not ensured that staff providing care or treatment to patients had the qualifications, competence, skills and experience to do so safely.

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment: The provider did not have a robust approach to ensure that restraint was used in the safest possible manner.

Regulation 17 HSCA (RA) Regulations 2014 Good Governance: The provider had not ensured that staff had received adequate security checks to provide care to patients. The provider had not ensured it had robust systems in place to manage and monitor the hospital risk register and the provider had not ensured its policies were up to date and reviewed.

We did not inspect against the requirement notices issued in May 2019 as this was a focused, unannounced inspection to follow up on specific concerns we had relating to the safe domain.

Following our inspection, we served an Urgent Notice of Decision because of the immediate concerns we had about the safety of patients. We told the provider they must not admit or readmit any further patients until further notice, they must submit a complete weekly log of the last seven days of incidents, they must undertake a complete, immediate and continuing review of all patients' risk assessments and care plans, they must undertake a complete and immediate review of all patient observation levels and they must carry out a weekly review of all medication errors and how the risk of the error being repeated is being addressed. We told the provider that they must provide CQC with an update relating to these issues on a weekly basis.

Our inspection team

The team that inspected Cygnet Hospital Stevenage consisted of two inspection managers and three CQC inspectors.

Summary of this inspection

Why we carried out this inspection

We carried out this focussed, unannounced inspection following a number of significant concerns raised regarding the quality of enhanced observations, updating risk assessments following an incident and the provider notifying CQQ about certain changes, events and incidents that affect their service or the people who use it. We had also received concerns surrounding the death of a patient detained on a ward.

How we carried out this inspection

We have reported on some of the key questions in the safe domain. As this was a focused inspection, we looked at specific key lines of enquiries in line with concerning information received. Therefore, our report does not include all the headings and information usually found in a comprehensive report.

During the inspection visit, the inspection team:

- visited five wards at the hospital;
- spoke with the registered manager and managers or acting managers for wards;
- spoke with 4 other staff members; including nurses and support workers;
- examined in detail, the care and treatment records of 24 patients:
- examined in detail, the observation records of 17 patients;
- tracked incidents recorded on the providers incident reporting database;
- 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 did not speak with patients during this inspection. This was a focused inspection to review specific concerns.

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?

Requires improvement

We did not rate this inspection. The ratings from the inspection which took place in May 2019 remain the same.

We found the following issues of concern during our inspection:

- Staffing arrangements meant the service relied heavily on agency and bank staff to ensure safe staffing numbers on the wards. Overall, there was a 56% vacancy rate for qualified nurses and support workers.
- We could not be assured that staff and patients were safe. Staff were not consistently updating patient risk assessments following incidents of violence or self-harm. Overall, 43% of risk assessments had not been updated adequately following an incident.
- Staff had not reflected patient individual risks within patients care plans.
- We could not be assured that the correct levels of observation were being used. We looked at 20 patient's observation records across wards. On most records the date of next observation review was incomplete, and we saw no evidence that reviews had taken place. Details on the front sheet showing levels of observation, reasons for enhanced observation and date of next review were missing on multiple dates.
- We could not be assured staff carrying out observations were doing so in accordance with policy. The provider internally reported 130 incidents of self-harm across wards within a two-month period. Of those 130 incidents of self-harm, many patients were being supported by enhanced observations.
- There was a high number of medication errors on Orchid ward. We could not be assured that managers had taken appropriate steps to monitor and investigate the number of discrepancies.
- Overall, 42% of incidents that were notifiable to CQC had not been submitted by the provider.

Are services effective?

Good

Not inspected as part of focussed inspection

Are services caring?

Good

Not inspected as part of focussed inspection

Are services responsive?

Good

Not inspected as part of focussed inspection

Summary of this inspection

Are services well-led? Not inspected as part of focussed inspection	**Requires improvement** 

Detailed findings from this inspection

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	Good	Good	Good	Requires improvement	Requires improvement
Forensic inpatient or secure wards	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

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

Requires improvement

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Requires improvement

Safe staffing

The service relied heavily on agency and bank staff to ensure safe staffing numbers on the wards. The hospital recruited agency staff on a short-term contract basis. At the time of inspection 179 support workers and 53 qualified nurses were in post across the hospital. Managers told us there were 76 support worker vacancies and 37 qualified nurse vacancies, which equated to a vacancy rate of 70% for qualified nurses and a 42% vacancy for support workers across the hospital.

Assessing and managing risk to patients and staff

We looked at nine sets of patient care records across acute wards. All demonstrated that staff assessed risks to patients and others by completing the Short-Term Assessment of Risk and Treatability (START) risk assessment tool on admission. All risk assessments had an update within the providers three-month timescale. However, staff had not always updated individual patients risk assessments following incidents.

On Orchid ward one risk assessment had not been updated following a patient's self-harm. However, the self-harm had been noted within the patient's case notes and within a comprehensive care plan on managing risk. Staff confirmed risk information should also be included within the updated risk assessment. One patient on Orchid ward had eight incidents of self-harm recorded with the risk assessment notes between 14 December 2019 and 16 January 2020 but the START risk assessment front page had not been updated to reflect the patient's risk of self-harm.

We looked at four care records on Chamberlain ward. One risk assessment had not been updated following an altercation between two patients on 28 December 2019 and the risk assessment was stored on the computer rather than in the patient's paper record. One risk assessment had not been updated following a patient damaging hospital property and threatening staff. One patients risk assessment made no reference to the patient's inappropriate behaviour towards staff.

We looked specifically at five patients signature risk signs on acute wards, signature risk signs identify risk factors that staff should be aware of and are written within the START risk assessment. Managers confirmed that signature risk signs should be reflected within the patients care plan. Overall, only one patient's full list of signature risk signs had been identified in their care plan. The other four patient's signature risk signs had not been recorded in full on their care plan. Two of those patients who were on Orchid ward had none of their identified signature risk signs reflected on their care plan.

We could not be assured that the correct levels of observation were being used. We looked at four patient's observation records on acute wards. Details on the front sheet showing levels of observation, reasons for enhanced observation and date of next review were missing on multiple dates between August 2019 and January 2020 for two of the four records. On most records the date of next observation review was incomplete, and we saw no evidence that reviews had taken place.

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

Requires improvement

On Orchid ward one patient's observation records did not indicate the level of observations required or the reason for the patient being observed for eight days between 09 December and 16 December 2019. This meant the patient may have been observed more or less frequently than required.

We could not be assured staff carrying out observations were doing so in accordance with policy. For the two-month period between 10 October and 10 December 2019 the provider reported 29 incidents of self-harm internally across acute wards. Of those 29 incidents of self-harm, 14 patients were being nursed on 1:1 observations and 12 patients were on intermittent, general or 15-minute observations. Incidents of self-harm were categorised into headbanging, swallowing, ligatures, cutting self, striking self/ object and other.

Medicines management

The hospital reported all errors or issues arising through medicines management using their internal incident reporting database. Between 10 July 2019 and 10 December 2019, 37 medication errors were recorded across the hospital, 29 of the medication errors were for the two acute wards. The highest number of medication errors was 23 errors on Orchid ward. We could not be assured managers were effectively performance managing staff who were making repeat errors. We spoke with managers who were aware of medication errors. However, learning and improvement had not been carried out with the staff involved.

Reporting incidents and learning from when things go wrong

Staff we spoke with on acute wards knew how and what incidents to report. Staff used a paper incident reporting system which were then uploaded on to an electronic database. We looked at incidents the provider had recorded internally on their electronic database between 01 July 2019 and 31 December 2019. We identified 25 incidents on acute wards requiring notification but only eight notifications had been made to CQC, this meant 68% of notifiable incidents had not been reported. The 17 incidents that had not been reported during this timescale included eight visits to accident and emergency, three episodes of self-harm resulting in injury, one police incident, an allegation of a staff member providing a patient with alcohol, two incidents of patients purchasing and using illicit substances whilst on Section 17 leave, a patient's asthma inhaler not being stocked and an AWOL (absent without leave) incident with police involvement.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?
(for example, treatment is effective)

Good

Not inspected as part of focussed inspection

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Not inspected as part of focussed inspection

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs?
(for example, to feedback?)

Good

Not inspected as part of focussed inspection

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Requires improvement

Not inspected as part of focussed inspection

Requires improvement

Forensic inpatient or secure wards

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are forensic inpatient or secure wards safe?

Requires improvement

Safe staffing

The service relied heavily on agency and bank staff to ensure safe staffing numbers on the wards. The hospital recruited agency staff on a short-term contract basis. At the time of inspection 179 support workers and 53 qualified nurses were in post across the hospital. Managers told us there were 76 support worker vacancies and 37 qualified nurse vacancies, which equated to a vacancy rate of 70% for qualified nurses and a 42% vacancy for support workers across the hospital.

Assessing and managing risk to patients and staff

We could not be assured staff had knowledge of patient's current risk levels. We looked at 15 sets of patient care records across forensic wards. All demonstrated that staff assessed risks to patients and themselves by completing the Short-Term Assessment of Risk and Treatability (START) risk assessment tool on admission. All risk assessments had an update within the providers three-month timescale. However, individual risk assessments were not always being updated following incidents.

On Pattison ward one patient's risk assessment had been updated following an incident on 01 November 2019 but had not been updated following an assault on staff on 06 November 2019 and there was no record of the incident within the patient's case notes. One patient's record on Pattison ward's electronic care plan differed to the paper copy located within their paper file. On another risk assessment it was not clear what the level of risk was for self-harm, suicide and violence as staff had not ticked a box to say if the risk was present. Two other risk assessments viewed on Pattison ward were highly detailed and had been updated following incidents of self-harm or violence.

On Peplau ward risk assessments were detailed and included comprehensive updates.

On Tiffany ward one risk assessment had been reviewed on 07 October 2019 but had no updates detailed within the risk assessment on that date, even though the patient displayed self-injurious behaviour on a near daily basis. One risk assessment for a patient on Tiffany ward had the violence section of the risk assessment updated with attempts to self-ligate but this was not reflected in the self-harm section of the risk assessment.

On Saunders ward, one patient's risk assessment had not been updated following threats of violence made towards staff and an episode of self-harm on 10 September 2019.

We looked specifically at six patients signature risk signs on forensic wards, signature risk signs identify risk factors that staff should be aware of and are written within the START risk assessment. Managers confirmed that signature risk signs should be reflected within the patients care plan. Overall, none of the patients had their full list of signature risk signs recorded within their care plan.

We could not be assured that observation reviews were taking place or that the correct levels of observations were being carried out. We looked at 16 patient's observation records for forensic wards. Details on the front sheet showing levels of observation, reasons for enhanced observation and date of next review were missing on

Requires improvement

Forensic inpatient or secure wards

multiple dates between August 2019 and January 2020 for 10 of the 16 records. On most records the date of next observation review was incomplete, and we saw no evidence that reviews had taken place.

On Pattison ward one patient being supported by 2:1 observation levels on 03 October 2019 had no entry indicated in their observation records from 07:00am until 16:30pm. For the same patient the observation records did not indicate the level of observations required or the reason for the patient being observed on 09 October2019 following the patient swallowing a foreign object. On Tiffany ward one patient who was on 15-minute observations had gaps in their observation records daily between 20 December and 28 December 2019, the longest being four hours with no recorded observation between 15:00pm and 19:00pm on 20 December 2019.

We looked at observation records for one patient on Tiffany ward between June and July 2019. On 28 July 2019 the staff member observing noted the patient 'appears asleep' between 22:30pm and 04:45am. This was not in line with the providers observation policy which stipulates that signs of life such as movement, breathing noted, talking or signs indicating the patient is safe should be recorded hourly.

For the two-month period between 10 October and 10 December 2019 the provider reported 101 incidents of self-harm internally across forensic wards. Of those 101 incidents of self-harm, 40 patients were being nursed on 2:1 observations, 14 patients were being nursed on intermittent, general or 15-minute observations, 12 were being nursed on 1:1 observations, eight were being nursed on 4:1 observations and six were being nursed on 3:1 observations. Incidents of self-harm were categorised into headbanging, swallowing, ligatures, cutting self, striking self/ object and other.

Medicines management

The hospital reported all errors or issues arising through medicines management using their internal incident reporting database. Between 10 July 2019 and 10 December 2019, 37 medication errors were recorded across the hospital, eight of these were recorded as medication errors for forensic wards. We could not be assured managers were effectively performance managing staff who were making repeat errors. We spoke with managers who were aware of medication errors. However, learning and improvement had not been carried out on the staff involved.

Reporting incidents and learning from when things go wrong

Staff we spoke with on forensic wards knew how and what incidents to report. Staff used a paper incident reporting system which were then uploaded on to an electronic database. We looked at incidents the provider had recorded internally on their electronic database between 01 July 2019 and 02 January 2020. On forensic wards we identified 35 incidents which required CQC notifications but only 17 notifications had been made, this meant 51% of notifiable incidents had not been made. The 18 incidents that had not been reported during this timescale included 11 visits to accident and emergency, one patient on staff assault resulting in injury, two patient assaults resulting in injury, three episodes of self-harm resulting in injury and one allegation of financial abuse.

We could not be assured that measures to prevent e-cigarettes being on wards were sufficiently effective. Forensic wards banned the use of e-cigarettes on 30 September 2019 due to the high risk of patients ingesting parts of e-cigarettes. However, on 16 November 2019 a patient on Peplau ward swallowed the filter part of an e-cigarette which resulted in the patient attending A&E.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good

Not inspected as part of focussed inspection

Are forensic inpatient or secure wards caring?

Good

Not inspected as part of focussed inspection

Are forensic inpatient or secure wards responsive to people's needs?

(for example, to feedback?)

Requires improvement

Forensic inpatient or secure wards

Good

Not inspected as part of focussed inspection

Are forensic inpatient or secure wards well-led?

Requires improvement

Not inspected as part of focussed inspection

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that risk assessments are reviewed and updated after an incident (Regulation 12)

The provider must ensure that observation records are completed in full and in line with the observation policy. The provider must ensure reviews are completed and they indicate the level of observation and reasoning for levels of observation (Regulation 12)

The provider must ensure that staff carrying out patient observations are doing so in line with the providers observation policy (Regulation 12)

The provider must ensure that they make notifications to external bodies including the local authority safeguarding and care quality commission as required (Regulation 12)

The provider must ensure that care plans reflect the patient's risks (Regulation 12)

The provider must ensure that medication errors are reviewed and investigated fully (Regulation 17)

Action the provider SHOULD take to improve

The provider should ensure the recruitment of substantive staff is a priority for the organisation and is regularly reviewed and monitored (Regulation 18)

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 • The provider had not made notifications to the care quality commission as required. • The provider had not updated risk assessments following incidents. • The provider had not ensured that observation records were completed in full and in line with the providers observation policy. The provider had not ensured reviews were completed and indicated the level of observation and reasoning for levels of observation. • The provider had not ensured that staff carrying out patient observations were doing so in line with the providers observation policy. • The provider had not ensured that patient risk levels were reflected in their care plans.

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 provider had not assessed, monitored or mitigated the risks relating to the high number of medication errors.