

Cygnet (OE) Limited

# Cygnet Hospital Hexham

## 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

Inspected but not rated



Are services safe?

Inspected but not rated



Are services well-led?

Inspected but not rated



# Summary of findings

## Overall summary

We have identified areas the registered provider must improve in relation to our concerns about this location. However, we did not re-rate Cygnet Hospital Hexham following this focused inspection. This is because the service type had changed since our previous comprehensive inspection in May 2019.


- The ward did not have sufficient space for patients to provide a safe and therapeutic environment. The dining and lounge areas were small and would not accommodate all patients at the same time if required to do so. Patients could not access the dining area without support from staff as it was accessed via a locked corridor. The seclusion room was small and provided patients with very limited space to move around[CB1] when the mattress was on the floor. It was located in a corridor that was the main thoroughfare for patients and staff to access the staff room, patient dining room, treatment room and laundry.

However;

- The ward environments were clean and well maintained. The ward had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly. New managers in the service were supported by regional managers and by a registered manager from another psychiatric intensive care unit in the region.

# 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	Inspected but not rated 	

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# Summary of findings

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# Summary of this inspection

## Background to Cygnet Hospital Hexham

Cygnet Hospital Hexham is a 27-bed mental health facility for women with complex mental health needs. Cygnet Hospital Hexham is an independent mental health hospital based on the outskirts of Hexham. The service has two wards, Fisher ward (17 bed acute ward), and Franklin ward (10 bed PICU) for females or 18 years and over. At the time of our inspection, Fisher ward was not open to admissions.

Cygnet Hospital Hexham is registered with the Care Quality Commission to provide the following regulated activities;

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

The hospital had a registered manager in place at the time of the inspection.

The service was last inspected in May 2019 when the service provided wards for adults with a learning disability and/or autism (named Cygnet Chesterholme). Following the inspection in May 2019, enforcement action was taken and the service was rated inadequate and placed in special measures. The hospital closed in September 2019 and re-opened in October 2020 providing acute admission and psychiatric intensive care wards.

## How we carried out this inspection

### How we carried out this inspection

We conducted a focused responsive inspection on Franklin ward in response to whistleblowing concerns in relation to patient safety. There had been several self-harm incidents where patients had required treatment in the acute hospital. We were concerned that the risks were not being managed well. We did not review all key questions; this was focused inspection of practice relating to these concerns within the safe and well led domains. We did not re-rate Cygnet Hospital Hexham following this focused inspection. This is because the service type had changed since our previous inspection in May 2019.

The team that inspected the service comprised of two CQC inspectors.

During the inspection visit, the inspection team:

- visited the ward at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- interviewed the Hospital Manager, Clinical Manager and one Clinical Lead;
- interviewed five other members of staff including nurses, support workers, advanced nurse practitioner and the consultant psychiatrist;
- spoke with two patients who were using the service;
- observed the morning meeting;
- reviewed three care and treatment patient records including a review of seclusion;
- reviewed incident records and observations

### What people who use the service say

# Summary of this inspection

At the time of our inspection there were seven patients on Franklin ward. We spoke with two patients who told us that they felt safe and that staff supported them and helped them with issues.

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 to improve:

- The service must review the environment on Franklin ward to ensure it provides a safe and therapeutic environment for patients. (Regulation 15 (1)(c)).

Action the service **SHOULD** take to improve:

- The service should continue with the recruitment programme to ensure that the hospital has a stable staff team who understand the needs of the patients who use the service.

# 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	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
<b>Overall</b>	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

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

Inspected but not rated 

Safe	Inspected but not rated 
Well-led	Inspected but not rated 

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

Inspected but not rated 

### Safe and clean care environments

The ward was safe, clean well equipped, well furnished, well maintained. However, the ward was small with limited access to communal areas.

### Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. There had been several incidents which had highlighted risks which had not been identified before the hospital had opened. A patient had been able to leave the hospital grounds from the garden. The investigation into this incident identified that improvements needed to be made to secure the garden area.

Staff could observe patients in all parts of the wards. However, we were concerned that the ward did not have sufficient space for patients to provide a safe and therapeutic environment. The dining room and lounge were small and would not accommodate all patients at the same time. Access to the dining room was through a locked door due to the location of the seclusion room. Patients could only access the dining room by asking staff to accompany them. There was one small multi-use room which was used as a visiting room, multi-faith room, and for one to one sessions. There was no designated area for ward activities to take place. There were seven patients in the hospital at the time of our inspection. We were concerned that the limited space would be even more challenging when the ward was full.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The environmental risk assessment had been updated on 12 April 2020. Staff had identified an issue with curtain rails, and these had been changed. The tables had been identified as having square corners and this had been reported to get them changed.

Staff had easy access to alarms and patients had easy access to nurse call systems.

### Maintenance, cleanliness and infection control

The ward areas were generally clean, well maintained, and well-furnished.

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

Staff followed infection control policy, including handwashing. Staff were wearing appropriate personal protective equipment.

### Seclusion room



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

Inspected but not rated 

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. However, the seclusion room was very small. Patients in the seclusion room had very limited space to move around the room when the mattress was on the floor. When the room was not in use, staff placed the mattress against a wall in the room to provide more space. When staff needed to enter the seclusion room, patients had to stand in the toilet area for staff to be able to enter the room safely. The corridor where the seclusion room was located was the main route for patients to access the dining area, treatment room and laundry. This was also the route for new patients being admitted into the hospital. This meant that there was a lot of people moving through the corridor, which was noisy and could disturb the patient when the seclusion room was in use.

## Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

## Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. However, the staff team were new and had limited experience of working in a psychiatric intensive care environment. Managers were aware of this and were supporting staff appropriately.

## Nursing staff

The service had enough nursing and support staff to keep patients safe.

The service had reducing vacancy rates. However, recruitment was still ongoing for the hospital and the service was using some agency staff to fill shifts. Managers ensured that they requested staff familiar with the service.

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

The service had reducing turnover rates. Some staff had left the service since it opened in October 2020. Recruitment for vacant posts was ongoing at the time of our inspection and managers told us they were keen to get the right staff in post rather than simply fill posts.

Managers supported staff who needed time off for ill health.

Levels of sickness were low.

Managers accurately calculated and reviewed the number and grade of nurses, and healthcare assistants for each shift. At the time of the inspection there were several staff in the service completing an induction.

The hospital manager could adjust staffing levels according to the needs of the patients and regularly increased staffing levels when acuity was high and there were patients who had increased observation levels.

Patients had regular one to one session with their named nurse.

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

Inspected but not rated 

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

Staff shared key information to keep patients safe when handing over their care to others.

## Medical staff

The service had enough daytime and night-time medical cover and a doctor was available to go to the ward quickly in an emergency. The doctor was currently shared with another hospital, but the permanent position was being advertised. There were two speciality doctors and an advanced nurse practitioner working at the hospital.

## Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

## Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed three patient records looking at patients who had been involved in recent self-harm incidents. Daily risk reviews had taken place and incidents were documented.

Staff used a recognised risk assessment tool.

## Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients. Risks were discussed in handovers and morning meetings. We observed the morning meeting and found this comprehensive.

Staff could observe patients in all areas.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. This was only used in exceptional circumstances.

## Use of restrictive interventions

Restrictive interventions were only used where necessary. There had been 75 restraints and 30 incidents of rapid tranquilisation used between 21 January 2021 and 20 April 2021. For the restraints 46 were high level, seven medium and 22 low level. In the 15 instances where de-escalation was not recorded this was due to the immediate threat to either the person, another patient or member of staff.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

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

Inspected but not rated 

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We saw evidence of this in the incident records.

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

Staff followed NICE guidance when using rapid tranquilisation.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. The record reviewed on inspection was found to be complete, however, an issue had been identified during a recent Mental Health Act monitoring which the hospital had responded to.

## **Safeguarding**

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

Staff received training on how to recognise and report abuse, appropriate for their role. We reviewed training data and found that all staff had completed safeguarding training.

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 and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We reviewed incident data and found that staff had made referrals to external agencies as appropriate.

## **Staff access to essential information**

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

Patient notes were comprehensive, and all staff could access them easily.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

Records were stored securely.

## **Track record on safety**

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Inspected but not rated 

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

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

Staff raised concerns and reported incidents and near misses in line with provider policy.

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

The service had no never events on any wards.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. A system had been put in place to allow clinical leads to review incidents graded as moderate and below to ensure that all incidents were reviewed in a timely manner. Managers met weekly to review all incidents which had occurred.

Staff received feedback from investigation of incidents, both internal and external to the service. There was evidence of discussion taking place around previous incidents which had taken place at the hospital. There had been several serious self-harm incidents in the hospital since it had opened. Managers and staff had reflected on these and had made changes to working practices in relation to assessing and managing patient risks. This had involved removing high risk items from patients identified as been at risk and increasing observation levels.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. This included a review of patients who were at risk of ingesting items and how to maintain patient safety on the ward. Security in the garden area had been improved following an incident.

Managers shared learning with their staff about never events that happened elsewhere.

## Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Inspected but not rated 

### Leadership

The hospital had a new management team who were new to a psychiatric intensive care unit environment. They were passionate about developing their skills and experience and were open and transparent about any development needs. Regional managers were working into the service to provide additional support to the hospital managers and other staff. An experienced manager of another psychiatric intensive care unit managed by the provider was also providing support into the service.

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

Inspected but not rated 

Overall, managers had a good understanding of the service and were visible and approachable for patients and staff.

## **Culture**

Staff felt respected, supported and valued by managers. Managers were accessible to staff working in the service. Staff said they were well supported by colleagues and managers.

Staff said the service promoted equality and diversity in daily work and provided opportunities for development.

Staff could raise any concerns without fear. Managers could give examples of where staff had raised issues and concerns, and these had been acted upon.

## **Governance**

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. We saw evidence of effective audit processes in place which had identified issues which managers had then acted upon. Managers had established weekly meetings to review all incidents within the service. Learning from incidents was shared across the whole staff team through bulletins, team meetings and in staff handovers. Managers had implemented a robust programme of audit and ensured that any issues identified were appropriately addressed.

## **Management of risk, issues and performance**

Staff had access to the information they needed to provide safe and effective care and used that information to good effect. Risks and issues had been identified and acted upon to ensure that staff and patients were kept safe.

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	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment <ul style="list-style-type: none"><li>The ward did not have sufficient space for patients to provide a safe and therapeutic environment.</li></ul>