Cygnet Hospital Taunton

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We rated Cygnet Hospital Taunton as inadequate because:

• All wards had blind spots which meant staff could not respond immediately to defuse potential assaults between patients or respond to a fall. Falls were not always recorded and falls plans put in place. Patients with a history of falls were not assessed by either a falls nurse or physiotherapist. Whilst the staff used observations to mitigate risk, we found some observation records incomplete. The provider acknowledges that line of sight could be improved in order to mitigate the risks posed.

• Risks to patients health such as pressure areas, nutrition and other health problems were not always monitored effectively. Information from discussions about patient care was not always recorded in records in a timely way. Pressure areas were not always checked and care records updated.

• We saw one patient who was left in bed until 12:30 despite asking to get up. Staff told us as the patient was mobile and that the patient had to stay in bed as staff were too busy delivering care to other patients.

• Staff did not follow best practice when administering medication. Medicines were not always administered at the correct time and important information was not always recorded on the prescription chart. Staff did not give patients information about what medicines they were about to receive. Directions for the administration of covert medication were not documented on the medication administration sheets. There could be long delays in obtaining medicines.

• Incidents were not always reported. We found incidents recorded in patients' notes but no incident form completed. During our visit we witnessed a patient fall. That evening the same patient fell again. We looked in the patients care records the following day and could find no record of the first fall.

• Patients' physical heath was not always assessed on admission or regularly reviewed thereafter. Important regular physical health checks were not always carried out.

• Assessments and care plans were not routinely reviewed and updated. There was little evidence of patient involvement in developing their own care plans. There was no system in place to support patients with dementia to make choices.

• The ward environments were stark and not suitable for those patients living with dementia. Bedrooms were not personalised nor decorated unless a family member came in to do this with a patient. There were restrictions on access to outdoor space.

• The hospital did not deliver any rehabilitation services and access to physiotherapy, occupational therapy and psychology to support rehabilitation was minimal. Patients with challenging behaviour had no psychological input and there were no systems in place to develop any behaviour support plans.

• There were 38 staff leavers between Feb 2015 and Feb 2016. Of these 38 leavers only one member of staff, a Health Care Assistant, was dismissed for gross misconduct in July 2015.

• Staff training was low in some areas and the induction of new staff was not always fully completed. Staff did not receive supervision in line with the provider's policy.

• There was a generally poor service for women at the hospital. Women on Willow ward had very limited space and could not be protected from a noisy environment. There was insufficient communal space on the ward and access to fresh air was via the male dementia ward.

• The provider had a governance system in place, however it had failed to identify and address serious shortfalls in care across the hospital. There was no effective system of audits in place to identify areas needing improvement.

However:

• The hospital maintained good health and safety checks.

• There was availability of equipment to assist with poor mobility.

Summary of findings

• Staff were caring, respectful and attentive to patients. Patients were complimentary about the staff. Patients were clean and tidy and relatives told us that this was always the case.

• Staff reported they felt well supported by their managers. There were regular integrated governance meetings and improvements had been made to hospital systems. Sickness and absence rates were low. There was good morale in the team. There were opportunities for career development for staff at all levels.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service

Summary of findings

Contents

Inadequate

Location name here

Services we looked at

<Delete services if not inspected> Urgent and emergency services; Medical care; Surgery; Critical care; Maternity; Services for children and young people; End of life care; Outpatients and diagnostic imaging; Termination of pregnancy; Hyperbaric Therapy Services; Dialysis Services; Diagnostic Imaging and Endoscopy Services; Refractive eye surgery; Long term conditions; Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient/secure wards; Long stay/rehabilitation mental health wards for working-age adults; Child and adolescent mental health wards; Wards for older people with mental health problems; Wards for people with learning disabilities or autism; Community-based mental health services for adults of working age; Mental health crisis services and health-based places of safety; Specialist eating disorders services; Perinatal services; Specialist community mental health services for children and young people; Community-based mental health services for older people; Community mental health services for people with learning disabilities or autism; Services for people with acquired brain injury; Services for people with psychosexual disorders; Outpatient services (for people of all ages); Substance misuse services; Substance misuse/ detoxification; ECT clinics; Psychosurgery services; Tier 3 personality disorder services; Liaison psychiatry services; Community health services for adults; Community health services for children, young people and families; Community health inpatient services; Community end of life care; Community dental services; Community health (sexual health services); Urgent care services;

Summary of this inspection

Background to Cygnet Hospital Taunton

Start here...

Our inspection team

Start here...

Why we carried out this inspection

Start here...

How we carried out this inspection

Start here...

Information about insert name of Location

Start here...

What people who use the service say

Start here...

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? Start here...	**Inadequate**
Are services effective? Start here...	**Inadequate**
Are services caring? Start here...	**Requires improvement**
Are services responsive? Start here...	**Requires improvement**
Are services well-led? Start here...	**Requires improvement**

Detailed findings from this inspection

Mental Health Act responsibilities

Start here...

Mental Capacity Act and Deprivation of Liberty Safeguards

Start here...

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Inadequate	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate

Notes

Outstanding practice and areas for improvement

Outstanding practice

Start here...

Areas for improvement

Action the provider MUST take to improve

Start here...

Action the provider SHOULD take to improve

Start here...

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.

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.