Cygnet NW Limited

Cygnet Hospital Sheffield

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-222659082	Cygnet Hospital Sheffield	Griffin ward	S2 3PX
1-222659082	Cygnet Hospital Sheffield	Unicorn ward	S2 3PX
1-222659082	Cygnet Hospital Sheffield	Pegasus ward	S2 3PX

This report describes our judgement of the quality of care provided within this core service by Cygnet NW Limited. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Cygnet NW Limited and these are brought together to inform our overall judgement of Cygnet NW Limited.

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Cygnet Hospital Sheffield provides child and adolescent mental health services for male and female adolescents aged between 13 and 18 years old and low secure services for women aged over 18.

We found the following areas for improvement:

- Staff did not ensure all patient records in relation to care planning and recording of administration of 'as and when' required medication were complete.
- There was inconsistency in the prohibited and restricted items for the three wards.
- Although the provider had introduced social distancing measures on the ward, these were not always adhered to by staff or patients.
- On Griffin and Unicorn wards, some furnishings and decoration were damaged and worn. However, the provider had ordered new furniture, but delivery had been delayed due Covid 19.

However, we found the following areas of good practice:

- Staff followed good policies and procedures for observations to ensure patients were safe and well. Staff understood and carried out the duties they were responsible for completing.
- The provider had made responsive changes to strengthen leadership and safety on the wards.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?
We found the following areas the hospital needs to improve:

- Not all patients had care plans for 'as and when required' medication and staff did not always record the reasons for administering this medication.
- There was inconsistency in prohibited and restricted items for the three wards.
- Although the wards had enough staff, the provider routinely relied on the use of bank and agency staff to meet minimum staffing levels.
- The provider had put into place some measures to promote social distancing, in order to minimise the risk of the possible transmission of Covid 19. However, during the inspection we saw some examples where staff did not always promote this guidance in practice.
- The provider did not always report incidents that they should have to us in line with their statutory duty.
- On Griffin and Unicorn wards, some furnishings and decoration were damaged and worn. However, the delivery of the replacement furniture was delayed due to the Covid 19.

However, we found the following areas of good practice:

- Staff followed good policies and procedures for observations to ensure patients were safe and well. Staff understood and carried out the duties they were responsible for completing.

In response to concerns raised about staffing, the provider had made changes to strengthen leadership and safety on the wards. This included ensuring more permanent staff worked evenly across day and night shifts, increased leadership on the wards at night including unannounced manager visits and more audits.

Are services effective?
We did not inspect this key question.

Are services caring?
We did not inspect this key question.

Are services responsive to people's needs?
We did not inspect this key question.

Are services well-led?
We did not inspect this key question.

Summary of findings

Information about the service

Cygnet Hospital Sheffield is an independent mental health hospital providing child and adolescent mental health services for male and female adolescents aged between 13 and 18 years old and low secure services for women aged over 18. The hospital has capacity to provide care for 55 patients across the four wards. These are:

- Pegasus: 13 bed mixed sex acute mental health ward for children and adolescents.
- Unicorn: 10 bed mixed sex psychiatric intensive care unit for children and adolescents.
- Griffin: 15 bed mixed sex low secure ward for children and adolescents. At the time of our inspection, the ward was limited to 11 beds because part of the ward was being used as an annex to provide care to one patient in long-term segregation.
- Spencer: 15 bed low secure ward for female adults.

The hospital has a registered manager. The hospital is registered to provide the following regulated activities:

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

We last undertook a comprehensive inspection of Cygnet Hospital Sheffield in 2016, at that inspection we rated the hospital as requires improvement overall. We rated the key question safe as inadequate, and the key questions effective, caring, responsive and well-led as requires improvement. We issued the provider with six requirement notices in relation to the HSCA (RA) Regulations 2014; Regulation 10 (Dignity and respect) 12 (Safe care and treatment) 13 (Safeguarding), 15 (Premises and equipment), 17 (Good governance) and 18 (Staffing).

Between our last comprehensive inspection in 2016 and this inspection, we have completed seven focussed inspections of Cygnet Hospital Sheffield.

In October 2016, we completed a focussed inspection following a serious incident. We told the provider it should ensure that staff update all risk assessments as soon as practicable in response to incidents so that they accurately reflect current risks for each patient.

In July 2017, we completed a focussed inspection following a serious incident on Haven ward (child and adolescent psychiatric intensive care unit). Following that inspection, we issued the provider with three requirement notices in relation to the HSCA (RA) Regulations 2014; Regulations 12 (Safe care and treatment) 13 (Safeguarding), and 17 (Good governance).

In August 2017, we completed a focussed inspection to follow up on previous regulatory actions. The provider had met the actions from previous inspections. However, following that inspection, we issued the provider with three requirement notices in relation to the HSCA (RA) Regulations 2014; Regulation 9 (Person-centred care), Regulation 16 (Complaints) and Regulation 17 (Good governance). We re-rated the key question of safe as requires improvement from the previous rating of inadequate.

In September 2017, we completed a focussed inspection following two serious incidents on the child and adolescent mental health wards. Following that inspection, we issued two requirement notices and told the provider it must:

- Ensure that risk assessments and care plans accurately reflect each patient's known risks. Staff must ensure these are updated when and where necessary, and in response to incidents where relevant. Patients must be able to contribute to, and inform these assessments and plans.
- Ensure records relating to patients care and treatment are accurate, current, complete and that staff and patients, where appropriate, review these at the appropriate frequency.

In December 2017, we completed a focussed inspection following an increase in safeguarding and incidents on the child and adolescent mental health wards. There were no regulatory breaches identified.

In July 2018, we completed a focussed inspection, on Peak View and Haven wards, to follow up on previous actions. We found that the provider had met previous actions.

Summary of findings

In May 2019, we completed a focussed inspection of Griffin ward following concerns about patient safety. There were no regulatory breaches identified.

Our inspection team

The team that inspected the service comprised three CQC inspectors. This inspection took place during the Covid 19 pandemic lockdown restrictions and this meant that we were unable to use Specialist Advisors or Experts by Experience.

Why we carried out this inspection

We carried out this focussed inspection in response to a whistleblowing and concerns about patient safety on the child and adolescent mental health wards.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

During this inspection, we focussed only on specific issues that had led us to undertake the focussed inspection. These were relevant to the key question 'is the service safe?'.

Before the inspection visit, we reviewed information that we held about the location. We undertook a risk assessment prior to our inspection, followed Public Health England guidance in relation to personal protective equipment, social distancing measures and our internal guidance during our inspection. We completed inspection activities off site where possible including document reviews.

During the visit, the inspection team:

- visited Griffin, Pegasus and Unicorn wards, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients who were using the service
- spoke with the registered manager, clinical manager and the child and adolescent mental health services lead
- spoke with 15 other staff members; including nurses, support workers and deputy ward managers
- observed one meeting with staff and patients
- spoke with seven carers
- carried out a specific check of PRN (as and when required) medication management for eight patients and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with nine patients and seven carers.

Summary of findings

Patients provided mostly positive feedback. They told us that they felt safe on the ward most of the time, staff supported them when they needed it and they felt confident in raising concerns with managers.

Patients told us that their experience of restraint was more positive when this was carried out by permanent staff who knew them better. One patient also told us that they felt that permanent staff cared more about patients compared to agency staff because they were more committed to caring.

However, two patients told us they thought that 'as and when' required medication was not always administered soon enough and because of this some incidents happened which could have been deescalated.

Carers provided mostly positive feedback about their experience of the service. Carers told us that overall, they thought that patients were safe at the hospital. Carers felt involved in care and treatment and thought staff communicated information well to them. Two carers told us that staff had adjusted the way restraint was used to meet individual needs. For example, where patients had a preference or a medical condition. One carer told us that they would like to visit more often. However, the hospital was following the Covid 19 visitor guidance issued by NHS England and Improvement.

However, three out of the seven carers we spoke to told about incidents that had occurred in the past where patients had been able to access risk items in the service. None of the incidents had resulted in physical harm to patients. One carer told us that staff did not handle a patient complaint appropriately. One carer told us that staff did not wear any personal protective equipment when a patient on Unicorn ward was isolating with symptoms of Covid 19 and following our inspection staff were still not wearing facemasks correctly because they were lowered under their chin around their neck.

Areas for improvement

Action the provider MUST take to improve

- The provider must maintain an accurate, complete and contemporaneous record of care and treatment provided. This includes ensuring there is a clear care plan for as and when required medication.

Action the provider SHOULD take to improve

- The provider should ensure that prohibited and restricted items are reviewed across the hospital to ensure this is appropriate for the individual care environments.
- The provider should continue to ensure that the number of permanent staff increases.
- The provider should ensure they notify CQC of all incidents specified in the published guidance.
- The provider should ensure staff and patients follow the practice of social distancing where possible in clinical areas in line with current guidance.

Cygnet NW Limited

Cygnet Hospital Sheffield

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Griffin ward	Cygnet Hospital Sheffield
Unicorn ward	Cygnet Hospital Sheffield
Pegasus ward	Cygnet Hospital Sheffield

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

We did not review Mental Health Act responsibilities as part of this inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review Mental Capacity Act and Deprivation of Liberty Safeguards as part of this inspection.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

Safety of the ward layout

An external contractor completed regular and comprehensive health and safety assessments of the care environment. The last assessment identified the hospital was 88% compliant with the standards set and a few small areas required action. Clear timescales for actions identified were set.

Staff also carried out assessments of the care environments for ligature risks. Appropriate measures were taken to manage and mitigate the risks identified.

The ward layout allowed staff to observe most parts of the ward. Staff presence in communal areas also aided their ability to maintain observation of any areas where clear observation was not possible.

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

Maintenance, cleanliness and infection control

All ward areas appeared clean. However, some furnishings and decoration were damaged and worn. In the quiet room on Griffin ward, there was graffiti on a wall and some items of furniture on Griffin and Unicorn wards were ripped exposing the stuffing. In the quiet room on Unicorn ward, there were bean bags that had been damaged and repaired. However, staff had not cleared away expanded polystyrene beads on the floor. This was a safety hazard and we raised this with managers. Managers told us that they had ordered furniture suitable for low secure wards to be delivered and safe bean bags, but the delivery of these items was delayed due to the Covid 19 pandemic restrictions.

The provider introduced social distancing measures with the young people as evidenced in community meeting minutes and records of education sessions. However, these were not routinely adhered to in clinical areas to minimise the risk of the possible transmission of Covid 19. Although, at the time of our inspection, there were no possible or confirmed cases of Covid 19. There was no information displayed on the ward about social distancing and no adjustments made to the ward environment to support staff and patients to maintain a distance from each other wherever possible. This included the nurses' stations and clinic rooms which were confined spaces. We observed staff and patients regularly next to each other. There were no attempts made by staff to discourage patients from being in close proximity of each other or staff or try to explain why maintaining social distancing was important.

The provider had developed guidance on the use of facemasks in line with Government advice where social distancing may be difficult to maintain. The new policy was implemented on the day of the inspection. At the start of our inspection, apart from staff caring for a patient in long term segregation, staff were not wearing any personal protective equipment. During our inspection, managers implemented the updated provider's guidance which required all staff to wear surgical face masks in clinical areas. On Griffin ward, we observed staff and patients were asked to gather for a meeting in the communal area. They were informed that the provider had decided that all staff would wear face masks from now onwards. Patients were also informed that they could wear a face mask but were advised a risk assessment would need to be completed prior to this. The provider had previously disseminated a presentation on personal protective equipment and guidance however, the content of this was not discussed during the meeting. Staff were provided with a surgical mask and asked to put this on straightaway. Staff had previously been provided with information relating to the use of personal protective equipment and 89% of staff had completed Covid 19 awareness training which encompassed the donning and doffing of facemasks. However, we saw that some staff lifted the masks downwards off the face when in the nurses' station. One carer also told us that when a patient was isolating with Covid 19 symptoms that none of the staff wore personal protective equipment. However, we did not observe any direct impact due to the use of personal protective equipment and the hospital was free from Covid 19 at the time of the inspection.

Safe staffing

Nursing staff

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

The provider relied on the use of agency and bank staff routinely to meet the safe minimum staffing levels for nurses and health care assistants. Managers used a staffing matrix to calculate the number of staff required on each shift. We reviewed four weeks of ward rotas and these showed that the number of nurses and healthcare assistants on shift was equal to or over the minimum safe staffing level for all shifts.

Managers had calculated the number of permanent nurses and healthcare assistants required and were undertaking recruitment up to target of 110% of the staffing establishment. The hospital was undertaking continuous recruitment to fill vacancies for nurses and health care assistants. This also included international nurse recruitment and nursing associate positions.

At the end of April 2020, the hospital's overall sickness rate was 11%. This included any staff absence due to Covid 19. Griffin had a vacancy rate of 28% for registered nurses and 12% for health care assistants. Pegasus had a vacancy rate of 18% for registered nurses and 16% for health care assistants. Unicorn had a vacancy rate of 8% for registered nurses and 18% for health care assistants.

Managers told us that they would prefer to use permanent and bank staff however, in order to meet the enhanced observation levels to keep people safe they had to use agency staff. The hospital used two agencies. A recruitment agency agreement was in place which outlined the requirements for agency staff including training. Wherever possible regular contracted agency staff were used and some of these contracted agency staff had worked at the hospital for several years. Contracted agency staff had the same responsibilities as regular staff and it was expected that they would attend team meetings and supervision.

All staff had an induction to the ward where information was shared so staff knew pertinent information such as including fire procedures and the location of ligature knives.

We received a whistleblowing concern relating to the leadership and safety of Griffin ward at night. At the time, many night shifts on this ward comprised mostly bank and agency staff. In response to this, managers took prompt action to investigate these concerns. They also implemented additional measures to assess and improve staffing on the wards at night. This included: ensuring that a senior nurse was on site for all shifts, more senior support workers appointed on Griffin ward, shift patterns reviewed to ensure that permanent staff were spread across all shifts evenly, increase in the frequency of close circuit television audits and senior management unannounced visits. There was a clear outline of the checks expected to be completed on unannounced senior management visits. Patients on Griffin ward reported that since this had started, they felt safer because more permanent staff were on shift at night and they had more knowledge of patients and their needs.

The hospital had created a child and adolescent mental health lead role and two of the four wards at the hospital had recently had a change in deputy ward manager which senior hospital managers hoped would also improve leadership in the service.

Mandatory training

Ninety seven percent of permanent staff had received and were up to date with training in the management of violence and aggression including restraint. The hospital required all agency staff to have completed and be up to date with all the required training to work any shifts at the hospital.

Assessing and managing risk to patients and staff

Management of patient risk

We reviewed observation records for all patients, and we reviewed eight patients' medication records.

Staff followed good policies and procedures for use of observation. All patients had an observation prescription plan which recorded their level of observation. At shift handover meetings, staff discussed observation levels. For each shift, a senior support worker completed a staff allocation sheet. The staff allocation sheet identified the duties that each individual member of staff was responsible for completing throughout their shift. This included medication, supervision, patient enhanced, intermittent or general observations, response, security and breaks. The nurse in charge signed off allocation sheets.

We checked observations records, and these were all completed correctly. On Unicorn ward, the observation board had a clock which was in time with the wards close circuit television to ensure that the record was accurate. On Pegasus ward, the general observation charts in use had been pre-printed with the hour. This meant that the time

on the chart was the time patients should be checked, staff had crossed out the time and recorded the time they had observed to be safe and well. Staff told us that pre-printed times made recording of observations more difficult.

Managers took appropriate action in response to concerns raised. A concern was raised to us about staff falling asleep on duty relating to April 2020. In response to this concern, the provider had implemented unannounced manager visits at night time to check staff were alert and carrying out their duties as expected. On the first of these visits, managers also identified staff asleep on duty. However, the way that these particular observations were required to be carried out exacerbated this issue, which was beyond the provider's control, and managers were working with commissioners to try and improve the conditions for staff. The provider was working with staff and had implemented measures to increase staff ability to carry out their duties as expected and to strengthen the oversight and assurance around this. This included planning regular breaks, rotation of staff, removing chairs for observation and additional checks to ensure staff were alert.

We found that some prohibited items listed for Pegasus (acute ward) were more restrictive than those on Unicorn (psychiatric intensive care unit) and Griffin (low secure ward). This included material suitable for people aged over 18, pornography and zinc batteries which were prohibited on Pegasus ward but not listed on the prohibited items list for Griffin and Unicorn wards. We were not concerned that these items were entering Unicorn or Griffin wards.

Staff and patients told us that the service tried to prevent prohibited and restricted items from entering the ward environments inappropriately. Despite staff efforts, they told us that there were a few occasions where this happened, but staff tried to ensure any risk items were located quickly so associated risks could be managed.

Medicines management

Staff and patients who were prescribed 'as and when' medication had a clear understanding of what type of medication was prescribed and when it could be administered. All patients and staff told us that at first staff tried to de-escalate patients by providing appropriate support, offering oral 'as and when' required medication first and as a last resort administering intramuscular as and when required medication if this was appropriate. Staff and patients told us that administration of intramuscular medication was rarely administered. We reviewed eight patients' medication cards which also confirmed this. Two patients told us that they would have liked as and when required medication to help them with agitation or anxiety to be administered sooner. These patients told us they thought that incidents occurred which could have been deescalated if they had been administered as and when medication sooner.

Doctors reviewed patients' medicines during ward round meetings about patients care and treatment. The frequency of administration of as and when required medication was discussed as part of this meeting and adjustments made to medication as deemed appropriate.

We identified issues with the completeness of records in relation to care planning and recording of medicines records in relation to as and when required medication. Seven out of the eight patients' records reviewed did not contain a care plan in relation to the as and when required medication that a doctor had prescribed. However, doctors had recorded the reason for use on the medication card. Six out of eight patients' notes did not contain a complete record about when this medication was administered. Staff did not always record in the patients' notes that the medication had been administered or the rationale why it was administered on that occasion.

Reporting incidents and learning from when things go wrong

Staff reported incidents appropriately and managers took appropriate action to notify the local safeguarding team or the police, However, a review of incidents for April 2020 identified one incident which the provider had not notified us of as specified in the Care Quality Commission (Registration) Regulations 2009. This meant on this occasion they had not carried out their statutory duty.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

We did not inspect this key question.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

We did not inspect this key question.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

We did not inspect this key question.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

We did not inspect this key question.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider had not ensured that all patients had a complete record relating to as and when required medication. This was a breach of regulation 17 (1) (2) (a) (b) (c).