Cygnet Behavioural Health Limited

Cygnet Victoria House

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 Victoria House following this focused inspection. This is because the service type had changed since our previous inspection in October 2018.

- The ward environments were impacting on patient safety. The limited communal space on Albert ward was contributing to conflict on the ward and the ward's environmental risk assessment did not reflect their current ward environment. Victoria ward was very large, and the layout meant that staff were unable to have oversight of patients in all areas of the ward. There were also instances when staff did not uphold Covid-19 infection control principles.
- The service's governance processes did not always ensure that ward procedures ran smoothly. There were errors, inconsistencies and omissions in multiple forms of documentation, including incident recording and frequent touch cleaning records. The monthly incident review meetings had not identified all areas for improvement in the use of restraint or the errors in incident documentation.

However:

- The ward environments were safe and clean. The wards 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 acting hospital manager had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

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	

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Victoria House

Cygnet Victoria House is a 26-bed independent hospital which provides in-patient care for men over the age of 18 years who had a primary diagnosis of mental illness with a secondary diagnosis such as challenging behaviour, complex needs or substance misuse.

Patients are admitted from across England and the hospital provides care and treatment for informal patients and patients who are detained under the Mental Health Act 1983.

The hospital had a registered manager and a controlled drugs accountable officer in place at the time of the inspection. (A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have the legal responsibility for the service meeting the requirements of the Health and Social Care Act 2008 and associated regulations. An accountable officer is a senior person within the organisation with the responsibility of monitoring the management of controlled drugs to prevent mishandling or misuse as required by law.)

The hospital has two wards:

- Albert ward, a nine-bed psychiatric intensive care unit (this was a seven-bed ward at the time of inspection);
- Victoria ward, a 17-bed acute ward.

Cygnet Victoria House is registered with the Care Quality Commission to provide the following regulated activities;

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

There have been seven previous inspections carried out at Cygnet Victoria House. The most recent inspection took place 29-30 October 2018, the hospital was rated as requires improvement overall. At that inspection, concerns regarding risk assessments, consent to treatment in accordance with the Mental Health Act, blanket restrictions on both wards and staff mandatory training were identified. At that time the hospital had an eight-bed acute ward and 22-bed rehabilitation ward; both wards had been changed at the time of this inspection. This was the first inspection of the service under its new formation. We did not review the concerns identified in the last inspection as this was a focussed inspection in response to specific risks.

What people who use the service say

Most patients spoke positively of staff and the service, saying it was "amazing" and that they "felt well looked after". Some patients spoke of conflict with other patients on their wards and said that staff responded well to this and were supportive. One patient did not feel safe and said that patients should be moved. One patient informed us that he stayed in his room to avoid conflict in the communal areas.

Patients who had been involved in, or witnessed restraint said that this was done in an appropriate and "professional" way.

Some patients reported that the wards would benefit from more staff but said that they had not had activities or leave cancelled.

Summary of this inspection

How we carried out this inspection

We conducted a focused responsive inspection in response to a rise in safeguarding notifications. Between 01 March and 20 April 2021 the service notified us of 11 incidents which included instances of racial abuse as well as one incident where inappropriate restraint had been used by a member of staff. This was a focused inspection looking at selected key lines of enquiry in the safe and well led domains that related to the concerns reported to us.

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

During the inspection visit, the inspection team:

- visited both wards at the hospital, 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 and acting hospital manager;
- spoke with 13 other staff members including nurses, health care assistants, bank and agency staff, occupational therapist and assistant psychologist;
- looked at seven care and treatment records of patients;
- looked at eight post rapid tranquilisation physical health monitoring forms and two seclusion records;
- reviewed seven incidents on closed-circuit television; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Areas for improvement

Action the service MUST take to improve:

- The service must ensure that patients on Albert ward have access to adequate communal areas. (Regulation 12(2)(d)).
- The service must ensure that staff on Victoria ward have effective oversight of all patients. (Regulation 12(2)(d)).
- The service must improve their governance processes to ensure that they address the errors and omissions in their environmental risk assessments and audits, monthly incident reviews and incident records. (Regulation 17(2)(c)(d)(f)).

Action the service SHOULD take to improve:

- The service should ensure that staff consistently uphold infection control principles.
- The service should consider improving staff's understanding of the duty of candour.

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
Overall	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

Safety of the ward layout

Staff could not evidence that they completed and regularly updated thorough risk assessments of all wards areas, and removed or reduced any risks they identified. The environmental risk assessments and ligature maps had not been updated to account for the changes to Albert ward as a result of building work taking place on the ward at the time of inspection.

There were potential ligature anchor points in the service. The environmental risk assessments did not identify all ligature risks in the environment (such as the air conditioning units or gates within the gardens). However, staff knew about any potential ligature anchor points, including those not identified within the environmental risk assessment, and mitigated the risks to keep patients safe.

Staff could not observe patients in all parts of the wards due to the layout. There was closed circuit television in place that covered all communal areas of the hospital. However, this was only shown on a screen in the manager's office and we were informed that this was only used to review incidents and not for observation purposes. Victoria ward was very large and had six separate communal areas (a games room, 1:1 room, two lounges, dining room and an occupational therapy space with games consoles and computers) that were set over two floors and open to all patients. Patients also had unsupervised access to the garden. Staff were not always present in all these communal areas and we were informed that the risk associated with the large space was mitigated by patients' individually risk assessed observation levels. However, we had concerns that the ward size may impact on patient safety. During an incident that we viewed on closed circuit television, patients were observed to be verbally aggressive and physically threatening to one another for four minutes before staff came from upstairs to de-escalate the situation.

Patients on Albert ward had access to a single, small communal space which served as both lounge and dining room. Group activities took place in this room and patients also passed through this area to access the ward garden. The communal room was not big enough to have dining chairs for all patients. The ward was also being modified at the time of inspection to increase the number of beds from seven to nine, further limiting the usability of the space. There was no quiet or de-escalation room, the de-escalation room previously in place had been changed into a new clinic room. The ward had 18 incidents of patient verbal or physical aggression towards other patients between 1 March and 21 April 2021 and we had concerns that the limited space was contributing to this conflict. One patient informed us that they stayed in their bedroom to avoid conflict in the communal area. Patients from Albert ward were able to use some of the communal areas (namely the occupational therapy station, multi-faith room and gym, which were also used by Victoria ward patients) but only if they were accompanied by a member of staff.

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

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained and well furnished.

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

However, staff did not always follow the infection control policy specific to Covid-19. Between 9 and 20 April 2021 the Covid-19 frequent touch cleaning forms for Victoria ward had omissions on six of the 11 entries reviewed. Two uncompleted entries were not dated and there were no checks listed for 10, 11 and 12 April 2021. We also reviewed seven closed circuit television recordings from within the hospital during March 2021; in two of these staff had their masks pulled down and it did not cover their nose or mouth, this had not been identified within the service's monthly review of incidents.

Seclusion room

The hospital had one seclusion room, on Albert ward, this had been recently fitted at the time of inspection. It allowed clear observation and two-way communication. The seclusion room had en-suite facilities and a clock, though the time shown was an hour behind.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs. Staff checked these regularly; however, there were some omissions in these checks. Albert ward had not completed three daily defibrillator and resuscitation bag checks and Victoria ward had missed one in the month leading up to inspection. Albert ward had also omitted one weekly tamper seal check on the resuscitation equipment bag in the same period.

Safe staffing

Nursing staff

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

The service had low rates of bank and agency nurses. The service used the same three agency nurses who were familiar with the service and patients.

The service had low rates of bank healthcare assistants and did not use agency healthcare assistants.

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

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. To cover sickness and vacancies, they offered staff overtime and that the wards provided support to each other. Some staff reported that they did not feel that they always had the appropriate number of staff on shift in recent months due to an increase in sickness, but said that they could gain the support of managers and off ward staff if necessary.

The ward manager could adjust staffing levels according to the needs of the patients.

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

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Each ward had an allocated activity coordinator who was not included within the ward numbers to ensure that patients had access to activities.

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. Handovers took place prior to every shift and each ward also had daily morning meetings as a multidisciplinary team to discuss patient care, risk and incidents.

Medical staff

The service had enough day-time and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incidents.

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.

We reviewed seven care records. All reflected the patients' incidents and risks and had risk management plans in place; except for one patient's record, which did not have a risk management plan for one of the patient's risks.

Use of restrictive interventions

Staff made attempts 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. Between 1 March 2021 and 21 April 2021 Victoria ward recorded 79 incidents; of these, 13 involved the use of restraint, 12 involved rapid tranquilisation and there were no instances of seclusion. For the same period Albert ward recorded 44 incidents; of these, 18 involved the use of restraint, six involved rapid tranquilisation and there were three instances of seclusion.

The hospital had reported an incident, which was under investigation at the time of inspection, in which a patient had been inappropriately restrained by a staff member. The provider had an incident review meeting in which staff reviewed all incidents on closed-circuit television to identify lessons learned. Staff spoken with during inspection were clear that

inappropriate restraint was not reflective of the service's training or values. There was evidence of immediate learning being shared following incidents and managers had adjusted staff training and taken disciplinary action where appropriate. Patients who had been involved in or witnessed restraint informed us that it had been carried out appropriately.

We reviewed seven closed circuit television recordings from within the hospital during March 2021; in two of these staff held the patient's arm with their hand which puts them at risk of bruising, this had not been identified within the service's monthly incident review meeting. We also had concern regarding the number of staff who attended the incidents, this had been identified during the service's review and was listed as an area for improvement.

Staff participated in the provider's restrictive interventions reduction programme and the service had reducing restrictive practice champions on both wards.

We reviewed eight post rapid tranquilisation physical health monitoring forms. These evidenced that staff followed NICE guidance when using rapid tranquilisation. However, staff did not consistently categorise rapid tranquilisation and it was difficult to distinguish within patient records whether rapid tranquilisation had been administered or patients' regular medication had been administered by intra-muscular injection.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. We reviewed two seclusion records, there were a small number of omissions in the forms. Neither noted the time that the doctors first attended the seclusion room. There was one signature, name and time missing from one patient's observation checks and one record did not note the incident number relating to the seclusion episode.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The service had raised 11 safeguarding alerts regarding racial abuse within the hospital between 1 March and 20 April 2021. We spoke with staff and patients about this concern and they were able to give examples of measures that had been put in place to safeguard patients and there was evidence of this within patients' risk management records. Patients told us that staff "did all they could" to protect them from racial abuse. One patient expressed frustration that the hospital had not discharged racially abusive patients and staff informed us that one of their main challenges when managing racial abuse had been difficulties in discharging patients to alternative services.

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.

Managers took part in serious case reviews and made changes based on the outcomes.

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

Staff raised concerns and reported near misses. However, it was unclear if staff knew what incidents to report and how to report them as staff did not always report incidents in line with provider policy and there were errors and omissions in incident records. For example, staff did not always select the correct options when categorising incidents of restraint and rapid tranquilisation within incident forms, meaning that not all incidents of restraint and rapid tranquilisation would have been identified during audits.

The service had no never events on either ward.

Not all staff spoken with understood what the duty of candour was; but staff reported that they were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Staff and patients were not always debriefed and supported after serious incidents. This had been recognised as a concern by the manager and lessons learned had been shared to try to address this.

Managers investigated incidents and a multi-disciplinary team met on a monthly basis to review all incidents on their closed-circuit television system. They assessed whether there were any lessons learned from the incidents and checked that patient's records had been updated appropriately. These findings were then discussed within clinical governance meetings.

Patients were involved in these investigations where applicable.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care and the learning from the monthly incident reviews was shared among staff. The monthly incident reviews then assessed whether these lessons were being implemented.

There was evidence that changes had been made as a result of feedback. For example, they had assessed that staff had not been seen to be engaging with patients prior to incidents starting on Albert ward; they shared this with the team and reported to have seen an improvement in staff engagement since this time. The shift teams on both wards had also recently changed to ensure there was an appropriate skill mix and staff reported that this had had a positive effect on both performance and morale.

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

Inspected but not rated

Leadership

Leaders had the skills, knowledge and experience to perform their roles.

They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

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

Inspected but not rated

Culture

Staff felt respected, supported and valued by their service managers.

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

Staff could raise any concerns without fear. All staff and patients spoken with said that they would be able to raise concerns with the nurse in charge or the hospital manager. The service's freedom to speak up ambassador actively advertised their role and staff knew who they were.

Governance

Our findings from the other key questions demonstrated that governance processes did not consistently operate effectively at team level and that performance and risk were not always managed well.

Albert ward's environmental risk assessment and ligature map had not been updated with the building works and environmental changes on the ward, and there were some omissions in the environmental ligature risk assessments for both wards. Actions on the environmental risk assessment had not been completed within specified timescales; of the 13 actions, 12 were due for completion 1 December 2020 and were listed as uncompleted.

There were missing entries in the defibrillator and resuscitation bag checks on both wards. Victoria ward also had between one and four omissions on six of the 11 Covid-19 frequent touch cleaning checks reviewed.

We reviewed seven patient care records and two seclusion records. One patient's record did not have a risk management plan for one of their identified risks and another had a daily entry in their notes for a different patient. There were small errors in both seclusion records.

We reviewed all 123 incident records listed between 1 March and 21 April 2021. There were inconsistencies and errors in how restraint and rapid tranquilisation was documented within these records. Staff had recorded that rapid tranquilisation had been used four, 12 or 18 times depending on which documentation was being reviewed. Post rapid tranquilisation monitoring had taken place on six occasions that had not been recorded as incidents. Staff described medicine being administered by intra-muscular injection but had not selected the box within the incident form to reflect that rapid tranquilisation had been used in eight incident records. Staff also did not consistently distinguish within patient records whether rapid tranquilisation had been administered or patients' regular medication had been administered by intra-muscular injection. Equally, four incident records described the use of restraint, but staff had not selected the correct box to identify that restraint had been used. These errors meant that when managers were auditing the frequency with which restraint and rapid tranquilisation had been used, they would not have the correct figures.

The monthly multidisciplinary incident review meetings had not identified all concerns noted in the review of closed-circuit television we carried out. Staff had pulled down their face masks below their nose and mouth in two videos and in two videos staff had held the patient's arm with their hand, putting them at risk of bruising.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Staff spoken with demonstrated a good knowledge of the patients in their care, their risks and the risk management processes in place.

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 Systems or processes were not established and operated effectively to ensure that the service maintained securely an accurate, complete and contemporaneous record in respect of each service user; including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. They did not maintain such other records as are necessary to be kept in relation to the management of the regulated activity; or evaluate and improve their practice in respect of the processing of this information. This was a breach of Regulation 17 (2) (c) (d) (f)

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 Care and treatment was not being provided in a safe way for service users because the premises used by the service provider were not safe to use for their intended purpose or used in a safe way. This was a breach of regulation 12 (2) (d)

Inactive