Cygnet Health Care Limited

Cygnet Hospital Wyke

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)
1-130486838	Cygnet Hospital Wyke	Acute wards for adults of working age and psychiatric intensive care units.	BD12 8LR

This report describes our judgement of the quality of care provided within this core service by Cygnet Hospital Wyke. 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 Hospital Wyke and these are brought together to inform our overall judgement of Cygnet Hospital Wyke.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Are services safe?	
Are services well-led?	

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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Overall summary

The inspection of Cygnet Hospital Wyke commenced on 8 November 2018 and was unannounced. The inspection was prompted by notifications of seven incidents following which two patients using the service sustained serious injuries. These incidents may be subject to criminal investigation by the Care Quality Commission and as a result, this inspection did not examine circumstances of the incidents. However, the information shared with CQC about these incidents indicated potential concerns about the management of risk such as falls from height, ligature risks, environmental risks, observation and engagement and staffing, this focussed inspection examined those risks.

We found the following issues that the provider needs to improve and have already taken urgent enforcement action to ensure improvements are made to the safety and management of the hospital. The service has begun to work on these improvements, and are engaging with the Care Quality Commission in this process.

- People were not safe and were at high risk of avoidable harm. This was because the safety systems, processes and standard operating procedures in place were not fit for purpose. This had caused unacceptable levels of serious incidents and incidents of harm to patients. There was limited measurement and monitoring of safety performance. Staff did not recognise concerns, incidents or near misses and missed opportunities to prevent and minimise harm.
- Staffing levels were not adequate, agency staffing was not well managed, staff had not completed all mandatory training, did not assess risk adequately, and did not carry out observations of patients as prescribed, which had all had a direct impact on patients
- The service did not give sufficient priority to safeguarding patients. Staff did not report all incidents to the local safeguarding authority and did not notify the Care Quality Commission of all incidents as per their registration regulations. This meant that other professionals could not be aware of the risks and issues to enable them to protect patients from harm.
- The hospital was not well led. The governance systems and process were ineffective because they had not identified the issues and risks for the service. There was a lack of ward level clinical leadership, this meant that the expectations of senior managers were not being met but there were no checking processes in place to identify this. There was little evidence of learning from events or action taken to improve safety. The culture of the hospital was poor, staff had low levels of morale and were highly stressed, they felt unable to raise concerns. The provider had failed to act on early indicators of this

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Summary of findings

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

Are services safe?

- The hospital premises were not safe because staff had not carried out sufficient environmental risk assessments and mitigated the risks presented. Patients had been able to access equipment and areas of the hospital which allowed them to come to harm.
- Ligature risk assessments were not present on Anderson ward to highlight these risks to staff. Ligature risk assessments on other wards had not been updated in response to a patient death involving a ligature.
- Staff did not manage the observation of patients well. There were reports of observations being missed and we saw evidence of patients being able to harm themselves at times when they were being monitored on enhanced observations. Staff did not always follow the prescribed level of observations with every patient.
- There were frequent staff shortages evidenced on staffing rotas. Staff and patients told us of low levels of staffing which caused an inability to complete therapeutic work with patients, allow them access to leave and fresh air, and allow staff time to complete tasks such as training, audits and action plans.
- Agency staff did not have access to electronic patient record systems, their training and skills were not monitored by the hospital and they did not always know patients well. The hospital used high levels of agency staff equating to 50% of staff in some months.
- We were concerned that due to Doctors covering more than one site, they had a significant workload which might mean that they may not be able to attend the hospital in a timely manner when a patient was admitted or when there was an emergency outside usual working hours. Admission rates outside usual working hours were high.
- Not all staff had completed mandatory training. This has been a concern at previous inspections of the hospital.
- Admissions processes and procedures did not ensure that patients' needs could be managed by the service and that risk was identified.
- There was insufficient attention to safeguarding patients because the service did not always make reports to the local authority.

Summary of findings

- Staff did not always assess, monitor or manage risks to people who use services; they did not carry out sufficient and thorough assessments of risk, and update risk assessments following incidents.

Are services well-led?

- There was a lack of ward level clinical leadership at the service. The actions set and required by senior managers of the hospital to ensure good quality care and improvements in practice were not followed up or were incomplete. The audit processes in place to monitor this were not robust.
- Staff had completed a survey which evidenced low morale and they told us that they felt a culture of blame had developed at the hospital. They described a lack of communication in relation incidents and learning. The service had not acted to address this culture.
- The governance systems were not robust, and there was a disconnect between the expectations of the senior management team and day to day ward practices.
- There was little understanding or management of risks and issues. There had been a significant failure in the systems in place to categorise, monitor and record risk. This meant that themes, trends and risks were not adequately identified and this prevented staff from learning from incidents and placed patients at risk of harm.
- When things went wrong the approach to reviewing and investigating causes was insufficient and too slow. There had been seven serious incidents at the hospital between 1 May 2018 and 31 October 2018. The service had failed to identify all the themes and risks from these incidents, and to share learning from these incidents with all staff and wards to improve practice.

Summary of findings

Information about the service

Cygnet Hospital Wyke is an independent mental health hospital provided by Cygnet Health Care Ltd. The hospital provides care for 55 male patients across three different wards:

- Austen ward is a 14 bed male psychiatric intensive care unit.
- Branwell ward is a 19 bed acute mental health ward for men of working age.
- Anderson ward is a 18 bed acute ward for females of working age.

The hospital has been registered with the Care Quality Commission since November 2010 to carry out the following regulated activities:

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

The Care Quality Commission last carried out a comprehensive inspection of this hospital in February 2018. At that inspection we rated the service as 'requires improvement' overall. At the time of this inspection, the hospital also provided care for older patients on Fairfax ward. This ward closed in August 2018. At this inspection the hospital was in breach of seven regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 9, person centred care: the care and treatment, statement of purpose and environment of Fairfax ward did not meet the needs of the patient group.
- Regulation 10, dignity and respect: there were blanket restrictions in place on Fairfax ward.
- Regulation 11, need for consent: patients on Fairfax ward were not always cared for within the provisions of the Mental Capacity Act.
- Regulation 12, safe care and treatment: infection control was not of good enough quality to keep patients safe on Fairfax ward.
- Regulation 13, safeguarding: acts to control or restrain patients were not always proportionate to the risk presented, and staff used planned prone restraint for the administration of intra-muscular medication.
- Regulation 17, good governance: Governance systems did not ensure that the service assessed, monitored and mitigated risks and improved the quality and safety of services.
- Regulation 18, staffing: staff had not completed mandatory training.

Prior to the comprehensive inspection completed in February 2018, a focussed unannounced inspection on Fairfax ward was completed in November 2017. This was in response to some specific concerns about serious falls and the use of management of aggression and violence techniques with older patients on this ward. We found the provider to be in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 12; safe care and treatment because of concerns about environmental safety, medications management and staff training.
- Regulation 17; good governance because contemporaneous records were not always kept and the provider was not aware of all the risks presented to patients.

At this inspection, the provider was also in breach of Regulation 18 (notifications) of the Care Quality Commission (Registration) Regulations 2009. This was because they had not made notifications to the Care Quality Commission about all allegations of abuse. We did not review previous breaches at this inspection as it was a focussed inspection of Fairfax ward only.

At the time of this most recent inspection, the registered manager of the service had left the organisation in October 2018. However, an interim hospital manager, who was experienced and qualified, was managing the hospital whilst recruitment processes were underway. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and the associated regulations including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

Summary of findings

Our inspection team

The team that inspected the service comprised five CQC inspectors including the team leader.

Why we carried out this inspection

We inspected this service in response to concerns relating to several serious incidents which had occurred at the service.

How we carried out this inspection

As this focussed inspection, we reviewed a number of key lines of enquiry relating to the following key questions:

- Is it safe?
- Is it well-led?

We reviewed; the safety of the environment, staffing, mandatory training the assessment and management of patient risk, use of restrictive interventions, safeguarding, medicines management, staff access to essential information, incidents and learning from incidents in the safe key question.

We also reviewed the hospital's leadership, culture and governance in the well-led key question.

Before the inspection visit, we reviewed information that we held about the location, asked the local authority safeguarding team for information, and reviewed information we had received relating to several serious incidents at the service.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with the interim registered manager, clinical manager and managers for each of the wards
- spoke with seven other staff members
- looked at nine care and treatment records of patients
- reviewed eight patient admission assessments
- reviewed staffing rotas
- carried out a detailed review of all incidents which had occurred at the service
- 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 six patients who were using the service during the inspection.

Patients descried staff as approachable, polite, helpful and respectful.

Whilst four patients commented that they felt safe and were always able to access the support of staff, one patient told us they didn't feel safe and two patients from the psychiatric intensive care unit told us that they had experienced assault and bullying from other patients.

Five of the six patients we spoke with told us that there were not enough staff, one described the ward as 'hectic' and three described activities and meetings being cancelled. Three patients told us that they had been unable to go outside for fresh air due to staff shortages.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the entire hospital environment is adequately risk assessed and these risks are mitigated.
- The provider must ensure that there is a reduction in incidents of harm to patients which are avoidable and preventable.
- The provider must ensure that patients from Austen ward are able to access outside space and that this can be safely managed by staff.
- The provider must ensure that ligature risk assessments are available to staff and regularly updated.
- The provider must ensure that staff complete observations of patients according to their risk assessment and according to policy and procedure.
- The provider must ensure that there are sufficient numbers of suitably trained and experienced staff with the correct skill mix to meet the needs of patients. Staffing levels must meet national guidance and be in line with the acuity and complexity of patients.
- The provider must ensure that all staff have access to essential information.
- The provider must ensure that all staff complete mandatory training.
- The provider must ensure that there is a robust system in place to ensure that temporary staff have the necessary skills, competence and training.
- The provider must ensure that doctors are able to attend the hospital within 30 minutes in a psychiatric emergency.
- The provider must ensure that all patient admissions to the service are adequately risk assessed and that staff are able to meet the needs of all patients prior to admission.
- The provider must ensure that staff complete all risk assessments and that these are updated when risks change or are identified.
- The provider must ensure that all incidents are correctly categorised and reported internally and via notifications to the Care Quality Commission and other external bodies as required.
- The provider must ensure there are mechanisms in place to ensure incident investigations are completed in a timely way and so staff are able to learn from incidents and make improvements to the quality of care.
- The provider must ensure that systems and processes in place to identify risk from incidents are effective and that adequate action plans are audits are completed.
- The provider must address the culture of the hospital to ensure staff morale is increased and staff feel supported and listened to.
- The provider must ensure that there is clear, effective ward level leadership that is aligned with governance processes.

Action the provider SHOULD take to improve

- The provider should monitor off-site prescribing to ensure any risk is mitigated.
- The provider should ensure they review the current culture relating to staff using restraint with patients.

Cygnet Health Care Limited

Cygnet Hospital Wyke

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Acute wards for adults of working age and psychiatric intensive care units.	Cygnet Hospital Wyke

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

Cygnet hospital Wyke had two acute wards for adults of working age; Anderson ward and Branwell ward. Both wards had 19 beds, Anderson ward is for female patients, and Branwell ward is for male patients. Anderson ward opened in September 2018. The hospital also had one psychiatric intensive care unit, Austen ward with 14 beds for male patients.

The ward environment was not safe because staff had not completed and updated risk assessments of the whole environment. Following a serious incident in July 2018 the provider instructed all wards to complete 'anti-climb' risk assessments, designed to assess the risk of patients being able to climb onto the roof of the hospital. These risk assessments did not contain information about other risks posed by the environment such as items which patients could use to harm themselves or others. For example, despite a serious incident in October 2018, storage of the cues and pool balls were not included in the environmental risk assessment. This meant that there was a lack of awareness of environmental risks and these risks had not been mitigated.

In response to an incident of a patient accessing the roof by climbing a drain pipe, managers had stated that patients from Austen ward would only be allowed outside access with three staff. This was to allocate one staff member to each drain pipe in the courtyard. Staffing levels on the ward meant that this was not possible. This courtyard also required staff and patients to access one steep flight of stairs for access. Should patients refuse to return from the courtyard, or become involved in an incident in the courtyard, staff would be required to use stairs whilst escorting a patient in restraint holds. Although the provider told us that staff training included the use of restraint holds whilst using stairs to escort patients, these risks were not present in the environmental risk assessment for Austen ward.

Staff could not clearly see all areas of the wards. Austen and Branwell ward had 'L' shaped layouts which did not allow staff a clear line of sight to observe patients. On Anderson ward the ward formed a 'T' shape which also created blind spots where staff could not see patients. However, the provider had installed mirrors to increase lines of sight for staff in these areas. All three staff offices were in central parts of the ward and were glass fronted, which allowed staff to observe patients on corridors and in communal lounges.

Areas of all wards contained ligature points including the communal areas, and patient bedrooms and bathrooms. A ligature point is something that a patient intent on self-harm could use to tie something to in order to strangle themselves.

The hospitals estates manager and each ward manager had completed a ligature risk assessment of each ward. These were last updated on 17 and 18 January 2018 on Branwell and Austen wards. This meant that these had not been updated since the time of a ligature related patient death in June 2018. Also, the ligature risk assessment on Anderson ward was not available on the ward at the time of the inspection and was updated on the day of our visit. There had been four ligature incidents on this ward since its opening in September 2018. Although none were from a fixed point, this highlighted the increased risk of this patient group to using ligatures for self harm.

The ligature risk assessments we reviewed stated that 'safety is maintained through individual risk assessments and subsequently therapeutic observations'. Staff confirmed that they were allocated to observe patients at intervals throughout the day and night. The level of observations was dependent on the risk presented by the patient. However, patients' observation levels were not always accurately adhered to. On Austen ward we reviewed the records of three patients. Two of these patients had observations set at 15 minutes due to their risk level. Staff told us that they were observing them at 30 and 60 minutes respectively according to the observations board, which was not in line with their risk assessments.

All wards complied with the Department of Health guidance on eliminating mixed sex accommodation because they were male or female only wards.

Are services safe?

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

Staff always carried call alarms and we saw these working during our inspection. Call systems were also available in communal areas and patient bedrooms.

Safe staffing

The service did not have enough staff who knew the patients and who had completed all the required mandatory training to keep patients safe from harm. At the time of inspection, the hospital had several vacancies and a high turnover of staff, reporting 34 staff leavers since January 2018.

On Austen ward, the psychiatric intensive care unit, there were 9.7 whole time equivalent qualified nursing posts, and 21.7 whole time equivalent health care support worker posts. Four nursing posts and two healthcare support worker posts were vacant at the time of the inspection.

On Branwell ward there were 10 whole time equivalent qualified nursing posts, and 22 whole time equivalent health care support worker posts. Two nursing posts and two healthcare support worker posts were vacant at the time of the inspection.

On Anderson ward there were 10 whole time equivalent nursing posts and 26 whole time equivalent healthcare support worker posts. Five nursing posts and three healthcare support worker posts were vacant at the time of the inspection.

Each ward had an allocated speciality doctor post. These posts were vacant on Austen and Branwell wards. The provider had employed locum Doctors to support the wards whilst recruitment was completed.

Staffing vacancies were identified as a concern on the hospital's risk register. The hospital had undertaken processes to enhance recruitment of staff by holding job fairs and advertising posts, but they remained unfilled.

The hospital was in the process of recruiting a new hospital manager, a quality and compliance lead, and a substance misuse assistant, as these posts were vacant at the time of the inspection.

The hospital used an internal staffing ladder to estimate the number of staff required per shift. The tool based the number of staff required according to the number of patients admitted to the ward.

The staffing ladder for Austen ward was not in line with the national association of psychiatric intensive care unit (2014) standards, which state that "staffing should be one third higher than acute wards (weighted per bed)." Staffing numbers on Austen ward were not much higher than staffing numbers on the acute wards. The staffing tools identified that six staff during the day, and five at night, were required for 10 to 13 patients. For 11 to 13 patients on the acute wards staffing was 5.7 during the day and four at night. Using this guidance, the psychiatric intensive care unit staffing should be 7.5 staff during the day and 6.65 staff at night. This meant that the staffing ladder did not consider the complexity and acuity of patients who required psychiatric intensive care.

During our review of the hospital's incidents which had taken place between 1 March 2018 and 31 October 2018 we saw direct impact on patient safety due to low staffing levels. In one incident, a staff member was left alone to staff Fairfax ward with four patients, one of whom required one to one observations. In a second incident, a patient was unsettled on Branwell ward but could not be given their 'as required' medication because there was not enough staff; the incident stated, 'PRN medication was warranted however was waiting for the arrival of the day staff due to short staffing issues in the hospital'. PRN medication is medication that is administered to patients as it is needed.

We reviewed the staffing rotas for the 24 hours on the dates that six serious incidents and five other incidents occurred, including patients absent without leave, a patient collapse and a police incident. Of these 22 shifts, staffing was below planned levels on 10 shifts. There was not a staff member allocated on the rota to act as 'emergency response' on 21 occasions. This is the staff member allocated from each ward who respond to emergencies across the hospital, as per the hospitals protocol.

The service did not ensure that there were always sufficient numbers of suitably trained staff on every shift. The service completed rotas for each shift. These identified which staff were working that day and were trained and able to use prevention and management of violence and aggression techniques. Out of the 22 shift rotas we reviewed, we saw that one shift on Anderson had only one staff member who was trained in management of violence and aggression techniques. Agency staff on these rotas did not have their management of violence and aggression techniques training status noted. The interim hospital manager told us that this was because the hospital expected that all agency

staff had this training before they could work on the ward. There was no checking process in place for this. In the same rota selection, there were three shifts on Anderson ward and four shifts on Austen ward where there were less than three permanent staff on shift who were trained in management of violence and aggression techniques. The interim hospital manager told us that required staffing for completion of management of violence and aggression techniques was three staff.

Ward managers told us that they could use bank and agency staff to support the wards when needed in response to staff vacancies and shortages. The hospital reported a high use of agency staff. The hospital manager had told us that the hospital used agency staff who were known to the service where possible, these staff had a contract to work for the service on a longer term basis. The service provided the following data which demonstrated that the majority of agency staff used were not contracted:

- April 2018: 41% agency use, 10% contracted
- May 2018: 41% agency use, 9% contracted
- June 2018: 50% agency use, 16% contracted
- July 2018: 44% agency use, 17% contracted
- August 2018: 14% agency use, 6% contracted
- September 50% agency use, 19% contracted
- October 21% agency use, 19% contracted

Staff did not always have access to the essential information required to care for patients. We had concerns about the high levels of agency staff because staff (including agency staff) we spoke with told us that agency staff could not use the Cygnet electronic patient record system. The senior management team were not aware that agency staff did not have access to electronic recording systems to review information including daily notes.

One ward manager told us that they preferred to use agency nurses at night and have permanent staff on shift during the day. On the rota's we reviewed there were sixteen shifts out of 22, where the only nurses on shift were agency nurses. There were two occasions at night when only agency nurses were on shift across the entire hospital and two occasions were only one nurse across the site was a permanent staff member. This was also high risk because of the 43 patients admitted to the hospital at the time of our inspection 20 of these patients were admitted during the night shift (after 7pm) outside doctor, ward manager and senior manager, normal working hours.

Patients and staff told us that staffing levels meant that they were not able to spend time with patients on a one to one basis or complete activities with them. On Austen ward, staff we spoke with told us that they had not had time to meet with patients who they were the named nurse for because the ward was so busy. One staff member told us that particularly on Austen ward, incidents often occurred because staff were not able to quickly respond to the needs of patients. They described that patients knocked on the office window repeatedly requesting support or for access to items such as their deodorant. Staff often didn't have time to respond and this was the cause of incidents on the ward. When we reviewed 309 incidents involving patient violence or aggressive behaviour between 1 March 2018 and 31 October 2018, we saw that 17 of these incidents on Austen ward began with patients seeking support at the nurse base which corroborated what staff had told us.

Medical staff

There was not adequate medical cover to provide support day and night, and doctors could not attend the wards quickly in an emergency. During the day, doctors were present in the hospital and each ward had a named doctor to provide care to patients. During evenings and weekends the hospital used an on-call rota. This rota comprised of one doctor who had responsibility for both the acute and psychiatric care wards at Wyke, one other psychiatric care unit approximately 20 minutes away at another hospital, and two low secure and one rehabilitation ward. This doctor was able to escalate concerns to one other doctor (a consultant psychiatrist) who was also on call for the same hospitals.

National Institute for Health and Care Excellence Violence and Aggression: short term management in mental health, health and community settings (NG10) states that staff trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend an emergency if restrictive interventions might be used. Accreditation for Inpatient Mental Health Services Standards for Inpatient Mental Health Services also states that the doctor needs to be able to attend the ward/unit within 30 minutes in the event of a psychiatric emergency.

We saw evidence in the integrated governance meetings minutes (August 2018) that doctors had raised concerns about this and had stated that with the introduction of

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Anderson ward the workload would be significant and that 75% of admissions at these sites were outside working hours, which meant they had significant time pressures and were not able to attend the site within required timescales for all incidents and admissions and provide a thorough and detailed admissions assessment.

Mandatory training

Staff did not always complete the required areas of mandatory training. There was a direct correlation at the hospital between actual patient harm and untrained staff. For example, when a patient fell from the hospital roof, the staff involved were not aware of the requirements of observing patients on an enhanced basis. We asked the service to provide us with evidence of staff training. Cygnet Health Care Ltd had a training compliance target of 95%. Staff carried out mandatory training in areas which included: basic and intermediate life support, prevention and management of violence and aggression, food hygiene, infection prevention and control, information governance, the Mental Capacity Act and Deprivation of Liberty Safeguards and the Mental Health Act awareness. We found low levels of training compliance in the following areas:

- Introduction to Monitoring Physical Health: Austen (67%)
- Rapid tranquilisation: Anderson (67%), Austen (58%), Branwell (57%)
- Clozapine: Branwell (56%) Austen 43%, Anderson (75%)
- Food safety: Austen (65%), Branwell (70%)
- Prevention and management of violence and aggression personal safety: Austen (50%)

In addition to the above, the following mandatory training courses were below the provider's own 95% target at the time of the inspection:

- Basic life support and AED: Anderson (93%) Austen (83%) Branwell (89%)
- Dealing with concerns at work: Anderson (87%) Branwell (77%)
- Equality and Diversity: Anderson (91%) Austen (88%)
- Immediate life support and AED: Anderson (83%)
- Prevention and management of violence and aggression: Anderson (88%)
- Protecting health and safety: Anderson (87%) Austen (92%) Branwell (83%)
- Infection Control: Austen (79%) Branwell (87%)
- Information governance: Austen (83%) Branwell (77%)
- Responding to emergencies: Austen (92%) Branwell (90%)
- Safeguarding individuals at risk: Austen (89%) Branwell (83%)

Assessing and managing risk to patients and staff

Assessment of patient risk

During the inspection we looked at the risk assessments of nine patients. Staff completed a risk assessment for each patient within 24 hours of their admission, and usually an initial risk assessment on receipt of their admission confirmation. Staff used a recognised risk assessment tool; the 'short term assessment of risk and treatability'.

Management of patient risk

We had concerns about the quality of six of nine of these risk assessments on Austen and Anderson wards. Risk assessments evidenced that staff were not aware of, or did not respond to specific patient risk, such as risk of patients going missing from the ward or misusing drugs or alcohol. Staff did not always respond to changing risks to or posed by patients by making amendments to risk assessments following incidents. For example, one patient had misused alcohol and their risk assessment was not updated after the incident. Leave risk assessments for one patient were not completed before section 17 leave. Two risk assessments did not have care plans linked to the management of the risk. One patient was assessed as being at high risk of becoming absent without leave, and their risk assessment was incomplete. One patient's risks assessments were inconsistently written in different parts of their assessment, high in one section and medium or low in a corresponding section.

Staff did not follow policy and procedure for the use of observation to minimise risk from potential ligature points. Patient observation levels were dependent on the risk levels of patients admitted. We found that the observation and engagement of patients was of poor quality. There had been three serious incidents at the service between May

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and July 2018; all three serious incidents indicated concerns about staff understanding of observation policy and practice. One of these incidents had resulted in the unexpected death of a patient. The clinical manager had put into place a new observation policy and procedure, however since these incidents occurred we saw 10 reported incidents of staff missing planned observations. We also found that there were 16 reported incidents of staff missing patient observations from 01/03/2018 to 12/06/2018 which may have given early indication of this required improvement of practice.

The service had an admission policy which described that on admission to the service, patients had a medical assessment with the admitting doctor. They then had a baseline physical health screening assessment with a doctor and a nurse, and following this (within seven days) a physical health intervention plan. We reviewed eight admission assessments. Five of the eight had no physical health baseline completed, two had no risk summary or initial care plan completed by the admitting doctor. One patient had been admitted to the service for several weeks and no physical health observation had been undertaken and there was no evidence of staff making attempts to complete this.

The service had a national Cygnet Health Care referral line. Staff were expected to respond to requests for admission to all three wards within a two-hour target. The hospital used a risk scoring system to assess a patient's risk level and decide whether the ward could meet that person's needs. Managers told us that the service did accept complex patients. There was no evidence of staff having enhanced training, or the service having specialist environments that enabled them to provide care to a more specialist patient group. Staffing levels did not take into account the time required by staff to undertake admission and discharge processes and there was an expectation that this was part of day to day ward business.

Four of seven ward level staff told us that they did not feel they were listened to when they refused admissions, two said that the patients being admitted were too complex or inappropriate. Two staff said there was a lack of referral information, one manager said that the referrals process did not consider acuity of the patient group and complexities.

Use of restrictive interventions

The hospital provided us with data which stated that between 1 May 2018 and 31 October 2018 there were 277 uses of physical restraint on Austen, Branwell and Anderson wards. The service had recorded 22 prone restraints in the same period. The prone restraint data was not reliable because on Austen and Branwell wards, prone restraint figures were not identified in the data.

There were 47 uses of seclusion and 44 uses of intra-muscular rapid tranquilisation within the same period. Intra-muscular rapid tranquilisation is a method by which staff use an injection of medication to immediately calm a patient. The highest uses of restrictive interventions were on Austen ward. At our last inspection in February 2018 we also reviewed six months of restraint data. Between 1 January 2017 and 1 July 2018 there had been 521 episodes of restraint (with the exclusion of Fairfax ward), 137 of these in the prone position.

There had been a 53% reduction in the use of physical restraint within a comparable period. The hospital had a reducing restrictive practice plan, managed by a lead nurse. The reducing restrictive practice forum met regularly to work on this agenda and staff continued to practice 'safe wards' techniques. However, when we asked staff about this reduction in restraint, two nursing staff told us that there was a 'hands-off' culture at the hospital as staff were worried about using restraint with patients, even when this was required to protect them and others.

Safeguarding

Patients were not always protected from abuse because staff did not investigate and report all incidents of abuse to the local safeguarding authority or follow internal procedures to ensure patient safety was ensured. In 70 incidents occurring between 1 March 2018 and 31 October 2018, there had been two occasions where safeguarding concerns were not reported to the local authority. On one occasion a patient had complained of, or had actual injuries following staff use of management of violence and aggression techniques. There was no report to the local authority or internal investigation following the reporting of these injuries by patients. We raised this with the service following the inspection and they agreed to make immediate safeguarding referrals and conduct a retrospective review of incidents to ensure there had been no further incidents of none reporting.

Staff access to essential information

Are services safe?

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

Staff worked from both electronic and paper patient records. The provider was moving to an entirely electronic system and this process was underway at the time of the inspection.

Staff told us that agency staff members did not have access to the electronic recording system, where patient's most up to date daily notes were stored. The management team at the hospital did not think this was the case. This was a risk because agency staff did not have access to all the essential information required to care for patients. This risk was increased because there were times when the only qualified nurses on shift were agency nurses.

Medicines management

Cygnet Health Care Ltd had a policy where doctors could prescribe medication over the telephone. We saw an incident whereby a doctor on call prescribed an unsettled patient a dose of intra-muscular medication. Staff used restraint to administer this medication. The provider's policy stated that:

"In exceptional circumstances it is acceptable to receive a verbal prescription over the phone from a doctor. Such circumstances may occur when no doctor is available on site and clinical judgements deem the service user requires medication. Two staff, one of whom must be a registered nurse, must always check the accuracy of the verbal prescription and record that both were involved in the clinical record. A verbal order is not, however, acceptable on its own and a confirmatory email or fax entry should be forwarded to evidence the prescription. The time scale for the duration of the verbal prescription should be specified and should not exceed 48 hours. A new prescription confirming the change should be written within 24 hours on weekdays, or 72 hours at weekends and bank holidays. Verbal prescriptions must never be given for CDs or drugs liable to misuse such as Temazepam as these are not legally permitted." It is not against guidance for doctors to prescribe medications in this way, when medications are not either controlled drugs, or drugs liable for misuse.

Whilst, the matter was discussed in the ward round within 72 hours of the incident, the action of the doctor did not follow the provider's own policy because they did not follow up the prescription in writing. This incident was not followed up by the hospital to provide learning or ensure the safety of the patient involved.

Track record on safety

Between 20 May 2018 and 30 October 2018 there had been seven serious incidents at the hospital which included the deaths of two patients.

Reporting incidents and learning from when things go wrong

There was a system in place for staff to report incidents. Staff knew how to use the system and how to report incidents.

Following an incident staff completed initial 24 and 72-hour reports. These were reviewed by the risk manager who decided whether a serious incident review was required in conjunction with the corporate patient safety committee.

There was a significant delay in these serious incident reports being completed and disseminated to managers, staff, patients and other interested parties, such as CQC. In recent serious incidents there have been delays of up to nine months between the incident and the completion of the report.

The service held serious incident review meetings following completion of these reports. However, only the staff involved in the incident were invited which limited opportunities for learning for other staff and other wards.

Between 1 March 2018 and 31 October 2018 there had been 1568 incidents at the hospital.

Four of the seven staff we spoke with and one patient told us that they did not always feel safe. Our analysis of incidents recorded by the service showed that between 1 March 2018 and 31 October 2018 there was an incident of violence approximately twice per day at the hospital. There were 213 incidents of actual and attempted physical, sexual and verbal abuse on patients, and 311 actual, attempted, physical, sexual and verbal abuse and staff accidents.

Out of 39 incidents we reviewed during the inspection, there were 18 incidents of harm caused to patients which were avoidable or preventable. These included incidents of patients harming themselves with objects or chemicals left on the ward, tying a ligature in the seclusion suite and a patient being served frozen food.

Incidents were often repeated because incident themes were not effectively monitored, meaning that early indication of risk was not highlighted to staff. For example,

Are services safe?

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

a patient suffered injuries following a fall from a roof in July 2018. The same patient had accessed the roof once before and had previously attempted to climb the fence, and their risk assessment was not updated by staff. In addition to these two other patients had also accessed the roof prior to this incident and no environmental risk assessment was completed or revised, or environmental changes made, to reduce the risk of reoccurrence. In October 2018 a patient suffered an injury requiring surgery. There had been two similar incidents in July 2018 and no action was taken to reduce risk.

Incidents were not correctly categorised by the service. Lack of appropriate categorisation of these incidents meant that they were not investigated, reducing the opportunity for learning and changes to practice, and there was a continuation of harm to patients because risk was not mitigated.

We noted that four incidents on Bramwell ward had been wrongly categorised as "attempted assault on staff" out of the 39 we reviewed. One patient had climbed a wall in Branwell courtyard and went up onto the fire escape, another had entered clinic room and threatened staff. In a third incident, the police had attended the ward to break down a barricaded bathroom door, in the fourth incident a patient had entered the nurse base and police attended to support staff to escort them to seclusion. The lack of appropriate categorisation of these incidents meant that the themes and risks identified had not been acted upon.

Staff had limited opportunity to learn from incidents and to share knowledge and experience. Managers told us that learning lessons from incidents was disseminated to staff in team meetings. We reviewed the last six months of team meeting minutes on all wards. They did not follow the set governance agenda as described to us, and there was little discussion of incidents. Staff on Austen ward had not had a team meeting since July 2018.

Staff also told us that risk and incidents were discussed at handover meetings twice daily. We wanted to review these notes but were informed that they were not kept. This meant that temporary staff, new staff, or staff returning from leave missed incidents and learning opportunities. We asked one staff member about a patient risk assessment who told us they could not answer our question because they had returned from two weeks' leave.

During the inspection we identified a number of incidents which had occurred at the hospital which were not reported to the Care Quality Commission. It is a necessary part of the provider's registration that they notify the commission of incidents. During the inspection we identified at least 70 incidents which had not been notified to us. This meant that we could not investigate these incidents, and ensure the provider was taking appropriate action to safeguard patients. We are managing this with the provider via a separate enforcement process.

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

Good governance

All senior staff from ward manager level met for monthly clinical governance meetings. A standardised agenda was discussed which included areas such as; medication management, compliance with the Mental Health Act, risk management, serious incidents, restraint, and safeguarding. Each agenda item had an attached action plan, which fed into the hospital's local overarching action plan. The local overarching action plan described actions required from incidents, inspections and concerns. This fed into ward level action plans which became the responsibility of ward managers. The ward level action plans we reviewed were incomplete, not dated and did not link back to the overarching local action plan.

For example, the action fed down to the ward level action plan from the overarching local action plan was

- 'to ensure the proper and thorough completion of observations following the unexpected death of a patient, future practice will include an observation of the ensuite area when evidence suggests that a service user should be located within the bedroom area".

The action taken at ward level stated;

- "to change the way that observations are conducted" and to follow this up in supervision.

The action plan status for this area had been changed to green for completed. There was no checking process in place to ascertain whether tasks had been completed by ward managers as per the action plans. The service had implemented a policy change whereby observation sheets required two signatures. There is an action on the overarching local action plan that says that observation practice would be reviewed in monthly audits, however, the audit for observation forms has not been amended to reflect the change in practice.

We reviewed governance meeting minutes from May to October 2018. Of note is that the hospital manager only attended one of five governance meetings. Although the governance discussions were detailed there was no recorded discussion of lessons learned from serious or other incidents. For example, there were references in minutes to themes around low staffing levels, lack of debrief after incidents, agency staff not having supervision, doctors reporting a significant increase in workload. However, there was no discussion or link of themes. When serious incidents or near miss were briefly discussed, there was no linking of the repeated themes and no associated actions.

There was a significant disconnect between the senior managers of the hospital and the ward level day to day practice. The systems and processes in place were insufficient and ineffective at managing risk and ensuring the service was safe. Systems for reporting and recording incidents, making notifications, holding team meetings, monitoring handovers and admissions and processes to quality check the care delivered to patients had all failed to capture the risks for the hospital and to the patient group.

Leadership, morale and staff engagement

Leadership

At the time of the inspection, the registered manager had left the employment of the service. An experienced interim hospital manager had been in post for four weeks. They were working part time at the hospital whilst they also managed another large hospital site.

The leaders of the service had a lack of awareness of the issues we identified during the inspection at ward level. There was a gap in effective leadership at ward level. Two of three speciality doctor posts were vacant on the wards and this meant that the medical leadership and ownership was lacking. There was little evidence and assurance of ward managers taking ownership in certain areas such as the completion of action plans, monitoring of mandatory training, making notifications, and conducting clinical audits and monitoring quality. Qualified nurses had stated to senior managers that they had not had sight of the last CQC report and that this had not been circulated to them. They had said that they had no awareness of a CQC action plan following the inspection in February 2018.

Culture

During the inspection we spoke with ten ward level staff. Staff gave us clear indications of low levels of staff satisfaction and high levels of stress. They had concerns about raising concerns for fear of retribution and talked about a 'blame culture'. They told us that staff had been suspended for making mistakes. Cygnet hospital Wyke had 34 staff leavers since January 2018.

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.

Cygnet Health Care Ltd had conducted a staff survey in February 2018 which also confirmed these concerns. One hundred and two staff at Cygnet Hospital Wyke had responded to the survey. In 35 questions only nine areas scored more highly than the 2017 survey, all other areas had a marked increase in negative feedback. Staff had made narrative comments about feeling ignored, a negative culture, a lack of teamwork, and fear of being managed out of employment for giving negative feedback about the service.

Despite this negative feedback about the culture of the hospital, the hospital had failed to act and at the time of the inspection the survey action plan remained in draft format.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** Service users were not protected from abuse and improper treatment because systems and processes were not established and operated effectively to prevent abuse of service users. The service did not report all allegations of abuse to the Local Authority. **This was a breach of regulation 13 (1) (2)**

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 **How the regulation was not being met:** Care and treatment was not provided in a safe way. The provider failed to assess the risks to the health and safety of service users receiving care or treatment and did not do all that was practicable to mitigate such risks. They did not ensure that the premises used were safe. **This was a breach of regulation 12 (1) (2) (a) (b) (c) (d)**

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:** Systems and processes were not in place or operating effectively to assess, monitor and improve the quality and safety of the service. The systems did not adequately assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. **This was a breach of regulation 17 (1) (2) (a) (b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** **The service had not provided sufficient numbers of suitably qualified, competent, skilled and experienced staff.**

This section is primarily information for the provider

Enforcement actions

Persons employed by the service had not received appropriate training as necessary to perform their role.

This was a breach of regulation 18 (1) (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **How the regulation was not being met:** The provider had failed to notify the Care Quality Commission of notifiable incidents as set out in the regulation. **This was a breach of regulation 18 (1) (2)**