Care Quality Commission

Cygnet Hospital Wyke

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

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

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

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

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

Overall summary

- Staff were positive about the changes at the hospital. Staff had received additional training in observations and in ligature risks. Staff knew what the current risks for the patients were. Staff were clear about the observations policy and how observations were recorded.
- Patients had risk assessments and risk management plans in place. Risks were discussed daily and updated in progress notes. Patients had care plans.
- The hospital had adequate staffing levels and there was no use of bank or agency staff.
- Managers were visible on the ward and were providing support to staff. Governance systems had been implemented.

Summary of findings

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Care Quality Commission

Cygnet Hospital Wyke

Services we looked at

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

Summary of this inspection

Background to Cygnet Hospital Wyke

Cygnet Hospital Wyke is an independent mental health hospital provided by Cygnet Health Care Ltd. At the time of the inspection the hospital provided care to male patients on one ward which had been renamed as Phoenix Ward and was previously a female ward. The other two wards were currently closed. An interim hospital manager was in post supported by the operations director. A permanent hospital manager had been appointed but had not started.

Previously the hospital provided care for 51 patients across three different wards which were:

- 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 an 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 carried out an unannounced comprehensive inspection of this service 2-4 June 2019. We had significant concerns following this inspection and used our enforcement powers under section 31 of the Health and Social Care Act to place conditions on the provider's registration. These concerns were in relation to breaches of the following regulations:

- Regulation 9 HSCA (RA) Regulations 2014; person centred care. The care and treatment of patients was not appropriate, did not meet their needs and reflect their preferences, due to a lack of activity, therapy and discharge planning.
- Regulation 10 HSCA (RA) Regulations 2014; dignity and respect. Service users were not always treated with dignity and respect.
- Regulation 11 HSCA (RA) Regulations 2014; need for consent. Care and treatment of service users was not always provided with the consent of the relevant person.
- Regulation 12 HSCA (RA) Regulations 2014; safe care and treatment. Care and treatment were not being provided in a safe way for service users. The service was not doing all that was practicable to mitigate such risks. Risk assessments were not completed and reviewed regularly. There was not the proper and safe management of medicines and their side effects. The premises and equipment were not safe and not used in a safe way.
- Regulation 13 HSCA (RA) Regulations 2014; safeguarding service users from abuse and improper treatment. Systems and process were not established and operating effectively to prevent abuse of service users and to investigate immediately upon becoming aware of any allegations of, or evidence of, abuse. Patients were not always protected from abuse and improper treatment because acts to control or restrain service users were not always proportionate to the risk presented.
- Regulation 17 HSCA (RA) Regulations 2014; good governance. Systems and processes were not established and operated effectively. The service did not assess monitor and improve the quality and safety of the services provided. The service did not assess and monitor and mitigate the risks relating to the health, safety and welfare of service users.
- Regulation 18 HSCA (RA) Regulations 2014; staffing. Staff did not receive appropriate training as is necessary to enable them to carry out the duties they are employed to perform.

Prior to the inspection in June 2019, the Care Quality Commission had also carried out a focussed unannounced inspection of this hospital in November 2018. This was a focussed inspection of the safe and well led key questions and was undertaken in response to

concerns relating to several serious incidents which had occurred at the service. The provider was found to be in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 13, safeguarding; the service did not report all allegations of abuse to the Local Authority.
- Regulation 12, safe care and treatment; 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.
- Regulation 17, good governance; the systems and processes in place did not identify, monitor and manage risk to patients.
- Regulation 18, staffing; staff employed by the service had not received appropriate training as necessary to perform their role.

Following this inspection in November 2018, due to the seriousness of the concerns, we took urgent enforcement action to ensure improvements were made to the safety and management of the hospital. This included placing conditions on the provider's registration to restrict the number of patients that could be admitted to the hospital until March 2019.

The provider was also in breach of Regulation 18 of the Health and Social Care Act (Registration) Regulations 2009, because they had not notified the Care Quality Commission of all the incidents at the service as required by this regulation. The provider paid a fixed penalty notice in relation to this breach.

Our inspection team

The team that inspected the service comprised two CQC inspectors

Why we carried out this inspection

An inspection of Cygnet Hospital Wyke's took place on the 31 October 2019. This was an unannounced inspection to check that the provider was meeting the requirements of the enforcement action from the responsive inspection on 19 June 2019.

At this focussed inspection we reviewed these specific concerns which related to the safe and well led key questions.

How we carried out this inspection

At this focussed inspection, we reviewed several key lines of enquiry relating to the following key questions on Phoenix Ward:

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

We reviewed;

- the safety of the ward layout, staffing, mandatory training, assessment of patient risk, and management of patient risk in the safe key question
- the hospital's governance and culture in the well-led key question.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- reviewed staffing rotas
- spoke with staff working on the ward
- reviewed staff allocation sheets
- reviewed the observation charts of four patients
- reviewed four care records
- reviewed incidents which had occurred between 1 and 31 October 2019
- spoke with two patients
- spoke with the ward manager

Summary of this inspection

- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with two patients who were admitted to the ward and asked them specifically about their safety and their understanding of their observation levels. Both said that they felt safe on the ward and that the staff were supportive and caring.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not re-rate the service during this focussed inspection:

- Care premises and facilities were safe. An environmental risk assessment was in place for the ward.
- Staff were undertaking observations of patients in line with the provider's own policy and the patient's care plan.
- The service provided mandatory and required training to staff.
- Staff were reporting all incidents which were reviewed by senior managers.

Are services well-led?

We did not re-rate the service during this focussed inspection:

- The service had systems and processes in place to monitor and assess risk.
- There was an understanding and management of risks and issues, and performance management and audit systems and processes had been put in place.
- The service was acting or acting in a timely manner in response to risk or when improvements were needed, including in response to the findings at our last inspection.
- Leaders had addressed the culture at the service and staff were now following policies and procedures to keep people safe.

Detailed findings from this inspection

Mental Health Act responsibilities

We did not review Mental Health Act responsibilities during this focussed inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review this during this focused inspection.

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

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Safe and clean environment

Safety of the ward layout

Staff did regular risk assessments of the care environment. Phoenix Ward had an 'T' shaped layout, which did not allow staff a clear line of sight to observe patients. The provider had acted to mitigate the risk by ensuring staff members were always allocated to the central area of the ward, where they can maintain line of sight down each corridor, observations of patients, and a staff office, which was centrally located.

All areas of the ward 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 strangle themselves. The ward manager and general manager had completed a ligature risk assessment of the ward. This had been updated within the last six months. The ligature risk assessment addressed all identified points and staff training had taken place. Managers were working with all staff to ensure that they were aware of potential ligature points. Staff confirmed that they were allocated to observe patients at intervals throughout the day and night. The ward had an accessible ligature point map in the staff office which gave a visual guide to staff of ligature points on the ward.

The ward complied with the Department of Health guidance on eliminating mixed sex accommodation because it was a male only ward.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff carried call alarms and we saw these working during our inspection. There was a system in place for staff to check their alarms were working at the start of each shift.

The ward was clean had good furnishings and was well maintained. Cleaning records were up to date and staff adhered to infection control principles including handwashing.

Staff were not using the seclusion room which was located on another ward. Any patient assessed as needing seclusion was not admitted to the hospital.

Safe staffing

Managers had calculated the number and grade of nurses and health care assistants needed. On the day of the inspection there were two registered nurses and eight health care assistants on shift. The hospital was not using bank and agency staff. There had been some staff members leave their posts since the closure of the wards and other staff members were working at different hospitals.

The number of support workers was increased according to the number of patients admitted, up to a maximum of five support workers during the day, and four at night when the ward reached capacity at 19 patients. However, at the time of the inspection the ward had four patients.

Staffing rotas showed that there was always the required number of staff on the ward and that there had not been any use of agency or bank since the ward had re-opened.

Staffing levels allowed patients to have one to one time. Managers were working with all staff to ensure that they understood the new systems that had been put in place.

There was adequate medical cover for the ward and patients had access to a doctor when needed.

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

All the patients that we spoke with said there were enough staff on the wards to meet their needs, spend one to one time with them and respond in an emergency.

Mandatory training

Staff had received and were up to date with mandatory training. Managers had worked with all staff including those not currently working at the hospital to ensure all staff were up to date.

Training for staff had included a virtual ward, risk assessment and care planning, ligature training which involved an external provider and gave staff practical exercises to complete. Staff had completed additional training on values, safeguarding and the role of multidisciplinary working.

Provider records showed that all staff working on the ward had received training in the observation and engagement policy in place.

Following concerns raised at our previous inspection, the provider had undertaken competency checks with all staff on their understanding of the observation and engagement policy.

The provider had launched a new observation and engagement protocol and paperwork on 31 May 2019.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff did a risk assessment with every patient on admission and updated this regularly.

We reviewed four care records. All four patients' care records had a risk assessment, which had been updated recently. Staff completed daily entries for each patient with a summary of current risks. Admissions were assessed by the multidisciplinary team and continued to be restricted.

The clinical lead had introduced daily board rounds to review observation levels, risks and management of patients. These were attended by the multi-disciplinary team and were well attended.

Management of patient risk

Staff identified and responded to changing risks to, or posed by, patients. Each morning, managers met for a morning communication meeting. They discussed risk levels within the hospital, staffing on the ward, estates issues, any incidents and any other issues which could affect the daily running of the hospital.

All staff attended handovers, which covered risks, observation levels, notable incidents and changes in patients' care plans. We checked the handover book for the last four weeks and found that staff recorded both morning and evening handovers.

Staff followed good policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms.

Staff had carried out patients' observations in line with prescribed observation levels. All four patient observation records we reviewed were complete. Observations were audited each shift by the nurse in charge, and then reviewed by the ward manager, and as part of the morning communication meeting. Any missed observations would be reported as an incident and investigated appropriately.

Patient observation levels were prescribed on admission and were dependent on the risk levels presented by each patient. In the records we reviewed, the admitting doctor had outlined the required observations in each patient's admission documentation. Observation levels could only be changed by the multidisciplinary team during daily board rounds. Staff felt that this was much safer than the previous system.

Staff applied blanket restrictions on patients' freedom only when justified.

There had been one restraint between 1 October and 31 October, and this had been to maintain safety during medication administration. The ward was not using seclusion at the time of the inspection.

Track record on safety

Between 01 October 2019 and 31 October 2019 there had been 21 incidents at the hospital and none in the last two weeks. The hospital had made two safeguarding referrals to the local authority about low level patient violence and aggression.

Reporting incidents and learning from when things go wrong

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

All staff knew what incidents to report and how to report them Staff completed a paper form, which was reviewed by managers and then uploaded onto the electronic system. The service had learned from and improved practice sufficiently in relation to serious incidents.

Staff received feedback from investigations of incidents both internally and externally. Staff had opportunities to learn from incidents in handovers, supervision and team meetings. The service also had a lessons learned log. It contained themes from incidents, serious incidents, national learning, and recommendations. Reflective practice and debriefs were taking place and a monthly newsletter was sent to staff with information from all hospitals in the area.

The service had made improvements to the way in which incidents were reported and reviewed. The hospital manager had developed a morning communication meeting which took place each morning at the hospital. The meeting involved a representative from all disciplines and all incidents were discussed including actions taken, any changes required and who these should be reported to. The Care Quality Commission had seen a significant improvement in the notification of incidents to us since our last inspection.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Not inspected

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Not inspected

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs?

(for example, to feedback?)

Not inspected

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Governance

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed

Our findings from the other key question demonstrated that governance processes operated effectively. Performance and risk were managed well. Weekly staff meetings were taking place and daily staff debriefs to ensure that staff felt supported and were able to raise concerns. Regular meetings were taking place within the hospital, which fed into regional meetings.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. Managers had implemented additional checks including audits to ensure that

observations were carried out appropriately. We found that staff were carrying out observations in line with prescribed levels. Senior managers had moved to an office just outside the ward to be more visible to staff.

Observations were being carried out appropriately. A new protocol for observations had been implemented. This protocol intended to ensure that staff would be allocated to a patient's continuous observations for a maximum of one hour and that observations would only be completed by permanent staff or staff known to the service. Allocation sheets showed that allocations were completed in line with the new protocol.

Staff manged patient risk on the ward. Staff maintained a record of handovers and managers had put in place systems to ensure this happened. This meant that the provider was assured patient risks and incidents were appropriately discussed or that patients' observation levels were consistently and appropriately transferred between staff teams working on different shifts.

Culture

Staff felt respected, supported and valued. Staff felt positive about working for the provider and their team. Managers had addressed both poor staff performance and a culture in the hospital, which did not support the delivery of safe care and treatment. Some staff had left the hospital and the remaining staff team continued to be supported.

Staff felt able to raise concerns without fear of retribution and knew how to use the whistleblowing process, and who they could raise concerns to.

Staff were now fulfilling their roles in line with the provider's policies. Staff were completing observations in line with the provider's policy and report any errors as incidents.