Cygnet Behavioural Health Limited

Cygnet Appletree

Inspection report

Frederick Street North
Meadowfield
Durham
DH7 8NT
Tel: 01913782747
www.cygnethealth.co.uk

Date of inspection visit: 21, 27 April and 14 May 2021
Date of publication: 25/08/2021

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 taken urgent enforcement action against the registered provider in relation to our concerns about this location. This included restricting new admissions into the service, without prior written approval of CQC (Care Quality Commission). However, we did not re-rate Cygnet Appletree following this focussed inspection. This is because the service type had changed since our previous comprehensive inspection in August 2019.

• Patients were not protected from abuse or poor care. Safeguarding issues were not always identified and reported to relevant agencies. This included reporting concerns to police, local authority and CQC.

• Patients were subjected to restrictive practices including restraint and the use of rapid tranquilisation. Staff did not always attempt to de-escalate incidents prior to using high level restrictions. Intra-muscular medications were used frequently without clear rationale to justify their use.

• Patients' privacy and dignity were not always protected when carrying out physical interventions, these were not used as a last resort and for the shortest possible time.

• Patients were not always protected from risks because the environmental risk assessment had not identified all risks. Seating in the courtyard had not been identified as a ligature risk.

• Observation records were not always accurate and did not reflect the level of observation patients needed to keep them safe as shown in risk assessments.

• Seclusion records and reviews of patients in seclusion were not completed in line with the Mental Health Act Code of Practice.

• Staff were not clear on what types of incidents should be reported. Staff did not always accurately record incidents. Systems in place to review incidents were not robust which meant that opportunities to learn from incidents were missed.

• Governance processes in the service were not effective. Managers had not identified all relevant issues as a result including environmental risks, use of restrictive interventions and safeguarding issues were not being addressed.

However:

• The ward environment was clean, well maintained and well furnished

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 Appletree

Cygnet Appletree is an independent hospital providing acute and psychiatric intensive care service for patients who are detained under the Mental Health Act 1983 and those who are admitted as informal patients.

The hospital provides care to female patients aged 18 years and over. The hospital is situated in its own grounds in Meadowfield, near to the city of Durham.

The hospital is split over two floors and has two wards: Bramley and Pippin wards. Bramley ward is a 16-bed acute ward providing care and treatment for females who are acutely unwell and cannot be treated and supported safely or effectively at home. At the time of our inspection, Bramley ward was not open for admissions.

Pippin ward is a 10-bed ward providing psychiatric intensive care and treatment for females whose illness means they cannot be safely or easily managed on an acute ward. Patients on psychiatric intensive care wards usually stay for only a short period before they can transfer to an acute ward.

At the time of our inspection there were eight patients on Pippin ward.

The hospital had a registered manager and a controlled drugs accountable officer. Controlled drugs accountable officers are responsible for all aspects of controlled drugs management within their organisation.

Cygnet Appletree has been registered with the CQC since 26 September 2012 and has been managed by two other providers during this time. In March 2018, the provider of Appletree became Cygnet Behavioural Health Limited.

Cygnet Appletree is registered 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.

Cygnet Appletree has previously been inspected eight times. The most recent inspection prior to this was 5 August 2020. This was a focussed inspection in response to concerns about patient safety and bullying within the service. No rating was given during the last inspection as the service type had changed from a high dependency unit in April 2020.

At our last inspection we took enforcement action against the registered provider in relation to concerns about the service. This resulted in a restriction on the numbers of new patient admissions to the service.

The findings in this inspection report relate to Pippin ward only as Bramley ward was not open at the time of our inspection.

We have taken urgent enforcement action against the registered provider in relation to our concerns about this location. However, we did not re-rate Cygnet Appletree following this inspection. We have been unable to rate the service as the service type has changed since our last comprehensive inspection in August 2019.

What people who use the service say

Summary of this inspection

Patients told us the service was always clean and tidy and they were generally happy there, the activities and food were good, and staff were nice. However, the patients we spoke with told us they had been restrained by staff and one person told us they had been assaulted by other patients on multiple occasions.

How we carried out this inspection

We conducted a focused responsive inspection of the service due to an increase in notifications and whistle blowing concerns.

We had received information that patient-on-patient abuse had increased, and we had concerns that the service was destabilised due to managerial changes. The registered manager was stepping down from their role and support being provided by the registered manager of another service. However, we found that the supporting manager was working across three sites and the level of support provided was less than expected.

We carried out a focussed inspection where we looked at specific key lines of enquiry in the safe and well-led domains.

The team that inspected the service comprised of a CQC inspector and a specialist advisor.

During the inspection visit, the inspection team carried out the following activities:

- Looked at the ward environment and observed how staff were caring for patients.
- Spoke with the registered manager and the operations manager.
- Spoke with four staff members including nurses and support workers.
- Spoke with two patients.
- Looked at the clinic room.
- Reviewed three observation sheets.
- Reviewed three care and treatment records of patients.
- Reviewed six incidents on closed-circuit television.
- Reviewed the notes of six incidents recorded on the provider's incident recording system.
- Reviewed three rapid tranquilisation physical health monitoring forms.
- Looked at three seclusion records.
- Reviewed 20 incidents of rapid tranquilisation involving two patients: and
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that an environmental risk assessment is in place which identifies all ligature risks and any actions to mitigate these risks. **Regulation 12 Safe care and treatment.**
- The service must ensure that the emergency drug bag is sealed so it is suitable for use in an emergency. **Regulation 12 Safe care and treatment.**
- The service must ensure that observation sheets for patients on enhanced observations provide a clear and accurate account of the level of observation required and where privacy is permitted. **Regulation 12 Safe care and treatment.**
- The service must ensure that seclusion reviews are carried out in line with the Mental Health Act Code of Practice and are fully documented. **Regulation 13 Safeguarding service users from abuse and improper treatment.**
- The service must ensure that episodes of seclusion are appropriate and used only when necessary as detailed in the Mental Health Act Code of Practice. **Regulation 13 Safeguarding service users from abuse and improper treatment.**
- The service must ensure the seclusion room has a clock which is visible to patients who are in seclusion. **Regulation 13 Safeguarding service users from abuse and improper treatment.**
- The service must ensure that guidance from the National Institute of Health and Care Excellence is followed in relation to the use of rapid tranquilisation. **Regulation 13 Safeguarding service users from abuse and improper treatment.**
- The service must ensure that patients' privacy and dignity are upheld during incidents of restraint and rapid tranquilisation. **Regulation 13 Safeguarding service users from abuse and improper treatment.**
- The service must ensure that restraint and rapid tranquilisation are used as a last resort and in line with the Mental Health Act Code of Practice. **Regulation 13 Safeguarding service users from abuse and improper treatment.**
- The service must ensure that systems in place to review incidents are robust. **Regulation 17 Good governance.**
- The service must ensure that records of incidents give a true reflection of what happened and include actions taken, debriefs and outcomes. **Regulation 17 Good governance.**

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

Safety of the ward layout

Staff completed and regularly updated risk assessments of all ward areas. However, we found that not all risks had been identified and action taken to mitigate these risks. There were wooden chairs in the courtyard area of the service. These had not been identified on the environmental risk assessment however, access was restricted, and patients were only allowed in the courtyard when supervised by 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.

Seclusion room

The service had a seclusion room which had recently been created on the ward. The seclusion room allowed clear observation and two-way communication. It had en-suite facilities but no clock to allow patients to see the time. However, a clock was ordered during the inspection period.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs. Staff checked these regularly. However, we found the emergency drug bag was not sealed and therefore may not have had the required equipment needed in an emergency.

Nursing staff

The numbers of nursing and support staff in the service were in line with required staffing levels.

Staff did not always operate in a manner to ensure patient safety. For example, staff did not always follow guidance when caring for patients in the service. Staff did not follow the Mental Health Act code of practice in relation to seclusion and we saw evidence that restraint was used before less restrictive interventions had been attempted. We raised concerns about the involvement of qualified nurses in three of the restraints we reviewed.

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

Inspected but not rated

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift.

The service had enough staff on each shift to carry out any physical interventions. However, we found inappropriate restraints were taking place and high use of intra-muscular medication, without less restrictive options being tried first.

Patients rarely had their escorted leave or activities cancelled. There was an activity coordinator in post who was not included in ward staffing numbers. This ensured that patients had access to activities when they were scheduled. Staff shared key information to regarding patients when handing over their care to others.

Medical staffing

The service had enough daytime and night-time cover and a doctor available to go to the ward quickly in an emergency. We saw one seclusion record that noted a doctor had not attended the service for a medical review because they were busy at another service and also found reviews were carried out by telephone, where medical staff were not present in the service. Seclusion records for two other incidents showed no medical review had been carried out but there was no justification for this.

Assessing and responding to patient risk

Assessment of patient risk

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

Management of patient risk

Staff knew about risks to each patient. Observation levels for patients were not always correctly recorded in line with patients' risk assessments. We found that observation sheets for patients on enhanced observations did not always give staff the information they needed to keep patients safe.

We reviewed observation sheets of three patients on enhanced observations and found one did not have the level of observation required for three out of five days, for the second patient we found there were different privacy levels for each of the five days. This meant that staff had allowed the patient private access to their bathroom and bedroom at times but had denied this at other times without any change in their level of risk. We also found the observation levels were not recorded for two further days. For the third patient we found privacy levels were different on each of the five days, observation levels were not recorded for one day, observation levels differed on three of the five days with no rationale recorded and one observation sheet was missing and could not be located.

We reviewed the records of all eight patients and found five of them did not have physical health care plans in place.

Staff followed procedures to minimise risks where they could not easily observe patients.

Use of restrictive interventions

Staff used restraint and rapid tranquilisation as a first line intervention. Staff did not always attempt to avoid using restraint by using de-escalation techniques and restraint was not only used when these failed or to keep the patient or others safe.

Staff prevented patients from leaving their bedrooms. We reviewed the CCTV in the service and found that patients who had been taken to their bedrooms in restraint were being prevented from leaving, with staff blocking the doorway with their bodies or locking and holding the door shut. These incidents were not recorded as seclusion and no action had been taken to safeguard patients during this time.

There was a high use of restraint in the service. Between 21 January and 18 April 2021 there were 162 restraints recorded for the service, 158 of which involved the use of medium holds or higher. We reviewed the closed-circuit television of six incidents recorded on the providers incident reporting system and found that restraint was used in all cases but not as a last resort. De-escalation was not recorded in all cases and there was no evidence of de-escalation practices on the incidents reviewed on CCTV. Staff were not maintaining patient's privacy and dignity whilst carrying out restraint and administering intra-muscular medication.

There was a high use of medication administered by intra-muscular injection in the service. Between 21 January and 18 April 2021there had been 108 incidents where medicines were administered by intra-muscular injection. Of these, 90 were categorised as rapid tranquilisation by the service. The use of intra-muscular medication was being used before oral medications were offered. We reviewed medicines administration documentation for two patients and found that intra-muscular medication had been administered on 20 occasions. Oral medications had been offered first on six occasions. Guidance from the National Institute for Health and Care Excellence states that rapid tranquilisation should be used if oral medication is not possible or appropriate and urgent sedation with medication is needed and that de-escalation should be used prior to restrictive practices.

We reviewed three post rapid tranquilisation physical health monitoring forms. These showed that staff followed guidance from the National Institute for Health and Care Excellence when using rapid tranquilisation.

Safeguarding

Staff did not always report abuse to relevant authorities. Staff had received training on how to recognise and report abuse, appropriate for their role. However, we reviewed the records of six incidents recorded on the providers' incident recording system and found that none of these had been referred to the local safeguarding authority.

Reporting incidents and learning from when things go wrong

Staff did not always raise concerns and report near misses.

Staff told us they knew what incidents to report and how to report them. However, we found serious incidents had not been recorded accurately in a way which is transparent and protects patients. We reviewed footage from closed-circuit television, we saw incidents that showed patients being restrained and should have been reported but weren't. We reviewed six incidents and found none of them had been reported to safeguarding. We found that incident records did not always accurately reflect what we saw happening on CCTV. Incident reports recorded that de-escalation had been attempted and this was not observed from our review of CCTV footage of incidents. We reviewed one incident which we compared with the incident record and found the patient involved was not the patient recorded on the incident report. In addition, whilst reviewing CCTV of an incident, we saw another restraint being carried out in the background, but there was no record of the second restraint in any records.

The service had not recorded any never events.

Staff and managers in the service did not always identify the issues and therefore weren't always giving explanations or apologies to patients when things were going wrong.

Staff and patients were not debriefed and supported after serious incidents. We reviewed six incidents and looked at the minutes of six morning meetings and found there was no evidence that actions were taken as a result, lessons learned or debriefs carried out.

Monthly meetings were held to review and discuss incidents which had been captured on closed-circuit television. However, we found that these reviews were not effective and had failed to identify any concerns or areas of learning.

Staff did not always receive feedback from investigations of incidents. Incidents were not always identified and therefore staff did not receive information on how incidents could have been more effectively managed. However, we did see a lessons learned folder in the service which provided staff some information on incidents that had happened in other areas.

Records

Seclusion records were not completed fully and accurately. We reviewed three seclusion records and found no medical review was carried out within the first hour of seclusion starting.

One record showed the first review took place four hours after seclusion started and the four-and eight-hour reviews took place at the same time, more than eight hours after seclusion started and these were carried out by telephone.

The second record showed that the first medical review included a reference to the patient being drowsy, benefitting from low stimulus environment and disturbing other patients. This was in direct contradiction to the Mental Health Act code of practice which states, 'seclusion should be used for the purpose of severe behavioural disturbance which is likely to cause harm to others.'

The third record showed two incidents of seclusion in the same day. However, there was no time or justification for seclusion in the second event and no evidence of reviews being carried out throughout the period of approximately 46 hours, although we were unable to be sure of the exact length of time due to the absence of appropriate documentation. There were some notes on observation sheets to say staff had been in to carry out reviews but there were no review notes present. In addition, the first observation note stated that the patient was asleep, therefore, there appears to be no rationale for seclusion at that time.

Staffhadeasyaccesstoclinicalinformation,anditwaseasyforthemtomaintainclinicalrecords–whether paper-based or electronic. However, records relating to patient observations were not accurate and were not always available to staff carrying out observations.

Patient notes were comprehensive, and all staff could access them easily.

Medicines

The service used systems and processes to prescribe, administer, record and store medicines. However, these systems were not always followed meaning some patients were at risk of receiving inappropriate medication.

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

Inspected but not rated

Patients did not have clear care plans outlining the use of pro-re-nata (PRN) medication and use of intra-muscular administration of medications or rapid tranquilisation. PRN medications are medicines that are used when needed. Staff used intra-muscular medication as a first line when attempting to control the behaviour of some patients and did not always give medication in the prescribed format or dose.

Decision making processes were not in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We reviewed 20 incidents of rapid tranquilisation involving two patients and found one patient was given rapid tranquilisation on 13 separate occasions between 2 and 19 April 2021. On nine of these occasions oral PRN medication was not offered first, and the patient was given a higher dose of medication than was prescribed on one of these occasions. The second patient was given rapid tranquilisation on seven separate occasions between 2 and 26 April 2021. On five of these occasions oral PRN medication was not offered first, and the patient was given a higher dose of medication than was prescribed on one of these occasions.

Staff did not always review the effects of medications on patient's mental and physical health according to National Institute for Healthcare Excellence guidance.

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

Inspected but not rated

Leadership

Leaders did not have the skills, knowledge, and experience to perform their roles. We found the leadership in the service was ineffective. Prior to the inspection, we received several whistleblowing concerns which stated that managers in the service were bullying staff and ignored concerns that were raised by staff.

Following inspection activity carried out in August 2020 we issued urgent enforcement action against the provider, which led to changes in the service. However, during this inspection, we found leaders were not able to implement and sustain the required improvements.

Managers did not have a good understanding of the services they managed, were not always visible in the service and approachable for patients and staff. Although some staff we interviewed told us the registered manager was visible and approachable, we were also told that some members of the management team were bullies, and staff were posting inappropriate content on social media.

Culture

We were told by staff that there was a 'toxic' culture and those who were friends with managers were not disciplined and were given preferential treatment. In addition, we were told the manager accepted the use of unnecessary restrictive practices.

The provider was informed of staff concerns and commissioned an independent investigation, a staff culture survey, an expert by experience and brought in a freedom to speak up guardian, to give staff confidence to speak out.

Staff used restraint and other restrictive practices as first line interventions, and this was a practice that was culturally acceptable within the service. Leaders did not robustly review or challenge inappropriate use of restrictive practices.

There was a culture of under-reporting incidents or not documenting incidents accurately. Safeguarding issues were not always appropriately identified and reported.

The service did not have a learning culture embedded. When incidents occurred, there was no system in place for de-briefs with staff or patients. Findings from investigations were not always shared with staff

Some staff we spoke with told us that Cygnet promoted equality and diversity in daily work and provided opportunities for development. However, we were told by other staff that the culture in the service was poor and that unless you were a friend of the manager it was difficult to get ahead.

Staff told us they did not always raise concerns as they did not always find the manager approachable and were afraid to speak to her about certain staff who were known to be friends of the manager.

Governance

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

Environmental risk assessments had not identified all ligature risks and therefore there was no action to mitigate these. The emergency drugs bag was not sealed and therefore may not have had all the equipment required in an emergency.

We reviewed three seclusion records and found reviews were not carried out in line with the Mental Health Act Code of Practice. Missing reviews had not been identified by managers within the service. For example, of the three records reviewed, we found no medical review had been completed within the first hour as required if seclusion is initiated by a nurse.

One record showed four and eight-hour reviews were completed at the same time and by telephone and the patient was put into seclusion due to 'benefitting from a low stimulus environment.'

The third record showed there were two episodes of seclusion in the same document. The second of these episodes lasted approximately 46 hours. There was no detail about the justification for seclusion and no evidence of reviews taking place, despite these being requirements as set out in the Mental Health Act code of practice. The provider was unable to provide a reason for this.

We are not assured that the systems in place to review incidents and identify learning from incidents was robust. We reviewed six incidents and found there was no evidence of actions taken, debriefs being carried out, outcomes or lessons learned. We also found that the narrative of incidents did not always match the closed-circuit television footage. This meant that the monthly review of the CCTV was not effective and that patients continued to be at risk due to the poor management and oversight of the incidents within the service.

We reviewed 20 incidents of rapid tranquilisation involving two patients and found staff had administered higher doses than prescribed, administered medications on multiple occasions that were prescribed for once only use and had administered medication which was not prescribed. This meant managers would not be able to gain a true reflection of incidents and restrictive practices when carrying out audits.

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

Inspected but not rated

Management of risk, issues and performance

Teams did not have access to the information they needed in order to provide safe and effective care. For example, our review of records showed that observation levels were inconsistent, reviews of staff practice failed to highlight concerns and safeguarding concerns were not always reported to the appropriate authorities.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The service did carry out reviews in line with the Mental Health Act Code of Practice in relation to seclusion. • The service did not follow guidance from the National Institute for Health and Care Excellence in relation to the use of rapid tranquilisation. • The service did not ensure that rapid tranquilisation were used as a last resort. • The service did not ensure that patients' privacy and dignity were protected, restraint was used as a last resort and for the shortest period of time.

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 • Incidents were not always reported to safeguarding, police or the Care Quality Commission. • Information relating to incidents is not always a true reflection of what has happened. • The service did not always carry out debriefs, record outcomes or lessons learned following incidents.

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

This section is primarily information for the provider

Enforcement actions

- The service had an environmental risk assessment in place which had been updated on 13 April 2021 however, chairs located in the garden had not been identified as ligature risks.
- The emergency drug bag located in the clinic room on Pippin Ward was not sealed.
- Observation sheets for patients that were on enhanced observations had discrepancies.
- Five patients did not have a physical health care plan in place.