Cygnet Hospital Wyke

Quality Report

Blankney Grange
Hudderfield Road
Bradford
West Yorkshire
BD12 8LR
Tel:01274 605500
Website:www.cygnethealth.co.uk

Date of inspection visit: 25 July 2016
Date of publication: 27/09/2016

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

Overall summary

We inspected the safe domain on Fairfax Ward at Cygnet Hospital Wyke

We also inspected the seclusion facilities in relation to the previous Care Quality Commission inspection on the 22 – 25 June 2015, where we found Cygnet Hospital Wyke to be in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the seclusion room did not fully meet national guidance requirements. At this inspection, we found that improvements had been made at Cygnet Hospital Wyke.

We also reviewed the incidents of restraint, including the use of face-down floor (prone) restraint on Fairfax Ward at Cygnet Hospital Wyke. This was because at the previous Care Quality Commission inspection on the 22 – 25 June 2015, we found Cygnet Hospital Wyke to be in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because they had not introduced measures to reduce the use of face down floor (prone) restraint by staff on all three of its wards. Face down restraint can put patients at risk of asphyxiation. We found that improvements had been made on Fairfax Ward where we completed this inspection.

Summary of findings

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Summary of this inspection

Background to Cygnet Hospital Wyke

Cygnet Hospital Wyke is registered with the Care Quality Commission to carry out the following regulated activities:

• Assessment and treatment for persons detained under the Mental Health Act 1983.

• Treatment of disease, disorder or injury.

A registered manager was in place at the location. 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 associated regulations, including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2010.

An accountable officer was also in place. The accountable officer is a senior manager who is responsible and accountable for the supervision of the management and use of controlled drugs.

The hospital had three wards:

• Austen ward – a male psychiatric intensive care unit for 14 working age adults.

• Branwell ward – a male acute inpatient mental health ward, for 15 working-age adults.

• Fairfax ward – a male ward, for 17 older men with behaviours that challenge.

The most recent Care Quality Commission inspection on the 22 – 25 June 2015, found Cygnet Hospital Wyke was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the seclusion room did not fully meet National Institute for Health and Care Excellence guidance and Mental Health Act code of practice. At this inspection, we found that improvements had been made at Cygnet Hospital Wyke.

Cygnet Hospital Wyke was also in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not introduced measures to reduce the use of face down floor (prone) restraint by staff on all three of its wards. Face down restraint can put patients at risk of asphyxiation. We found that improvements had been made on Fairfax Ward where we completed this inspection. Start here...

Our inspection team

Team leader: Emma Hatfield

The team that inspected the service comprised of two Care Quality Commission inspectors.

Why we carried out this inspection

We carried out this unannounced inspection in response to information we received which raised a number of concerns about the standard of care on Fairfax ward. Fairfax ward is the ward for older men with mental health problems who have behaviours that can be challenging. The information provided stated that:

- the ward was unclean and smelt of urine
- the patients were on the wards and attending external appointments in clothes that were not clean
- there was a high use of agency staff who were not familiar with the patients' needs, moving and handling equipment was not being used when it was required
- the patients were spoken to disrespectfully and aggressively
- incidents were under-reported and not recorded

Summary of this inspection

During this inspection we took the opportunity to confirm whether Cygnet Hospital Wyke had made improvements to their wards for older people with mental health problems since our last comprehensive inspection of the trust on the 22 – 25 June 2015.

When we last inspected Cygnet Hospital Wyke in June 2015, we rated the service as good overall. We rated the service as requires improvement for Safe, good for Effective, good for Caring, good for Responsive and good for Well-led.

Following this inspection we told Cygnet Hospital Wyke that it must take the following actions to improve its services:

- The provider must make sure that the seclusion room and de-escalation room are safe and meet national guidelines.
- The provider must introduce measures to reduce the use on patients of face-down floor (prone) restraint by staff. Face down restraint can put patients at risk of asphyxiation.

We issued Cygnet Hospital Wyke with two requirement notices. These related to:

A breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment. The provider had not introduced measures to reduce the use of face down floor (prone) restraint on patients by staff.

A breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Premises and equipment. We found the seclusion room did not meet national guidelines. This was because:

- A member of staff could not see the whole of the seclusion room from either of the two observation panels.
- The seclusion room did not have an intercom that the patients could use to communicate with the staff.
- The mattress in the seclusion room did not have the appropriate raised head for the patient to use as a pillow.

How we carried out this inspection

We asked the following question of Fairfax Ward only at Cygnet Hospital Wyke:

• is it safe?

Before the inspection visit, we reviewed information we held about the service including statutory notifications sent to us by the service. A notification is information about important events that the trust is required to send to us.

During the inspection visit the inspection team:

- visited Fairfax Ward and looked at the quality of the ward environment
- spoke with the acting ward manager and the registered manager
- spoke with two other staff members.
- looked at three treatment records of patients
- carried out a specific check of the maintenance of the ward
- looked at documents relating to the running of the ward

The inspection team specifically checked the incidents of restraint, including the use of face-down floor (prone) restraint on Fairfax Ward. This was in relation to the breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at the last inspection between the 22 June 2015 and the 25 June 2015, where we found the provider had not introduced measures to reduce the use of face down floor (prone) restraint on patients by staff.

The inspection team also specifically checked the seclusion room that was used for patients from all three wards at Cygnet Hospital Wyke. This was completed in relation to the breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at the last inspection between the 22 June 2015 and the 25 June 2015, where we found that the seclusion room did not fully meet the requirements of national guidance.

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?

- Areas of the ward, including the small quiet lounge, were not clean and smelt of urine.
- Some of the easy chairs in this temporary lounge had drink and food stains on them, as did the walls, and some of the wheelchairs stored temporarily in the lounge were stained and required cleaning.
- In the patient en-suite bathrooms and the ward bathroom we found the floor to wall seal was coming away from the wall in some places, and the shower chairs were stained and staff had not cleaned the underneath of them.
- Some patient bedrooms required further cleaning, some duvets were stained and a patient's mattress was wet with urine underneath, which staff did not notice whilst making the bed.
- Where discrepancies were found when staff checked medicines, these had not been reported for investigation.
- The provider was still to confirm a more appropriate course of training for physical intervention following an incident where a patient had been injured and the recommendation of an independent review into the incident.

However, we found the following areas of good practice:

- The required equipment and medication were available and accessible.
- The staff members had alarms and knew how to respond to incidents and the number of staff on shift was adequate to meet the needs of patients.
- Patients could access a range of activities and escorted leave and this was facilitated by staff.
- Patients had up to date risk assessments completed by a nurse and the assessments were reviewed regularly and after incidents.

Wards for older people with mental health problems

Safe

Are wards for older people with mental health problems safe?

Safe and clean environment

We conducted a tour of Fairfax ward. At the time of our inspection, the provider was carrying out construction work to extend the building. Part of the works was to add five large bedrooms to the ward. As a result, the provider had cordoned off part of Fairfax ward, which meant the main lounge was not accessible. Until the works were completed, the ward dining room was being used as a lounge for patients and patients were being escorted to the hospital dining room off the ward.

During the tour of the ward, we found that some of the easy chairs in this temporary lounge had drink and food stains on them, as did the walls.

We found some patient bedrooms required further cleaning. Some duvets were stained and one patient's duvet had become thin where washing had moved the filling around. A patient's mattress was wet with urine underneath, which staff did not notice whilst making the bed. We also found the patient's metal bed base was rusted and stained in places. The bedrooms were carpeted which meant they were difficult to keep clean and some were heavily stained.

There was a small quiet lounge, which had an unpleasant smell because the waste paper bin had urine in it and a chair that was wet. Some of the wheelchairs stored temporarily in the lounge were stained and required cleaning.

In the bathroom and patient en-suite bathrooms we found the floor to wall seal was coming away from the wall in some places, and the shower chairs were stained and staff had not cleaned the underneath of them.

Staff told us when clothing was heavily soiled they would rinse them in either the hand wash sink in the laundry or with the shower attachment in the patient bathroom. This meant patients and staff were at risk of the spread of infection.

The clinic room was clean and tidy. Daily checks were made of the resuscitation equipment and fridge and room temperatures. Medication was stored in lockable cabinets. Controlled drugs were stored in the locked clinic room and in a locked cabinet within another locked cabinet. Staff recorded controlled drugs and these were regularly checked by staff for accuracy. Staff stored drugs liable for misuse in a locked cabinet and these were recorded when administered and checks made for accuracy. However, we found the recordings for co-codamol 8/500mg effervescent tablets were inaccurate. There were 60 tablets recorded on 12 July 2016 and when checked staff found there were actually only 50 in stock. On the 22 July there 46 co-codamol recorded and when staff checked there were actually 44 in stock. Staff had not alerted the manager to these errors, which meant they had not been investigated to find how the error had occurred or why there were several tablets missing.

During our visit to Fairfax ward, we reviewed ligature risks and found there were several ligature risks throughout the ward and patient bedrooms. However, the provider carried out annual environmental and ligature risk assessments, which had identified the ligature risks. Each ligature risk was rated high medium and low. Ligature risk were mitigated by patients risk assessments which included an assessment of their risk of self-harm. Staff told us if patients were at risk of self-harm observation levels would be increased and where possible items which presented a ligature risk would be removed from their bedrooms. Cygnet Wyke were in the process of upgrading the patient bedrooms on Fairfax ward, which included anti-ligature taps. The work to the bedrooms had been paused whilst the building works were being carried out. This was to try to minimise patient disruption. The manager told us patient bedroom upgrades would continue when the building works were completed in August 2016.

Staff carried personal call alarms to keep them and patients safe. All staff reported that they had access to personal call alarms. A response team responded for support if staff activated the alarms.

Safe staffing

The provider used a tool to calculate the number of staff required for the number of patients. At the time of our visit

there were 13 patients on the ward which meant there should have been two registered nurses and three healthcare assistants on duty. At night there was one qualified staff member and three healthcare assistants. However, due to the increased needs of the patients on the ward the number of staff on duty during the day was 14 and 12 staff at night. Rotas' showed there were two registered nurses on duty at all times. There had been three occasions when at night the qualified staff on the ward had been provided by agency staff. This was due to the temporary increase in staff required across the service whilst the building improvements were in progress, and due to the increased levels of observations required for a number of the current patients. However, on these occasions the agency nurse had access to additional support from the regular qualified staff on the other two wards in the hospital. The ward manager told us this was not continuing and other wards in the hospital were providing qualified cover for the ward.

The staffing levels were often maintained using bank and agency. The registered manager told us they had given bank staff temporary contracts and 'block booked' agency staff in order to ensure consistency of care for patients. The registered manager told us that the majority of bank and agency usage had been due to increased patient need and admission to hospital of another patient who required staff to be with them at all times. The staff sickness record for the service was 0.4% at the end of June 2016.

Patients had access to regular leave and activities. Staff we spoke with told us planned leave was only cancelled when there was a change with the patient's presentation that would make it unsafe to take them out of the building. The records showed patients did receive regular leave. There were sufficient staff on the ward to facilitate a number of activities for patients. They included, group sessions of crafts, games and quizzes. In addition, there was sufficient staff for patients to have twice weekly trips out to the local pub for a meal. This enabled patients to maintain their social skills.

Assessing and managing risk to patients and staff

Staff completed risk assessments for patients and regularly updated particular risks when identified or incidents had occurred. Care plans demonstrated an individualised approach. Where patients had not signed to say they had been involved with their care plans, we saw staff had recorded the reasons for this and there was evidence of this being reviewed.

At the previous inspection on the 22 – 25 June 2015, we found that Cygnet Hospital Wyke was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we found that the provider had not introduced measures to reduce the use of face down floor (prone) restraint by staff. Face down restraint can put patients at risk of asphyxiation.

We reviewed data on the incidents involving restraint for all three wards at Cygnet Hospital Wyke for the three months prior to the inspection. The data showed that there were 186 recorded incidents involving restraint, which involved 16 patients in this three month period.

We looked at information relating to how the hospital was working towards reducing the use of prone restraint. We saw that 'Reducing restrictive practice' training of all staff had taken place.

It was mandatory for staff to complete training on physical interventions and this was refreshed on an annual basis. Not all staff had completed this training. However, those that had not completed it had been booked on to the course.

An independent investigation had been completed at the request of the service following an incident in April 2016 where a patient had been injured during a physical intervention. This independent investigation identified that the method of physical intervention used for the patient group on Fairfax ward may not be suitable. We spoke with the registered manager about this and they told us they were in the process of identifying a method which would be more appropriate.

On Fairfax ward, staff told us prone restraint was not used. The staff we spoke to on that ward told us de-escalation would first be tried and restraint was always a last resort. We reviewed records of the incidents of restraint for the last three months on Fairfax ward and confirmed this.

Therefore, at this inspection, we found that improvements had been made on Fairfax Ward where we completed the inspection.

Wards for older people with mental health problems

An audit of current practice on Fairfax ward had been carried out earlier in 2016 to see whether restrictions were in place. This identified that the ward did not have any restrictive practices in place.

At the previous inspection on the 22 - 25 June 2015, we found Cygnet Hospital Wyke was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we found the seclusion room did not fully meet national guidance requirements.

The hospital had one seclusion room which could be used for patients on all three wards when required. We looked at the concerns identified at the previous inspection, including the observation panels to enable staff to see the patient in all areas of the seclusion room, the intercom so that patients could communicate with staff whilst in seclusion, and an appropriate mattress which met national guidelines.

Improvements had been made to the seclusion room following our last inspection in June 2015, which meant it now met with the required standards.

However, the registered manager told us that seclusion was never used for the patients of Fairfax ward.

Staff were trained in safeguarding and policies and procedures were easily accessible in the nurses office.

Safeguarding incidents were communicated at handover meetings or earlier. We reviewed three care records and saw evidence of reporting incidents to safeguarding by the staff team.

Track record on safety

The hospital reported there had been 10 serious incidents on Fairfax ward in the 12 month period prior to the inspection. We observed details of an incident involving a patient restraint, including a detailed investigation and the actions taken as a result. This included staff and patients being offered support and a debrief after the incident.

Reporting incidents and learning from when things go wrong

All staff were expected to take responsibility for reporting incidents. Staff reported incidents on the incident recording documentation and gave appropriate examples of doing so. Reports were sent to the ward manager and trends were identified. These were discussed at the multi-disciplinary team meeting, clinical governance meetings and handover meetings.

The hospital had a structure for reporting incidents, investigating and cascading the information for managers to share with staff. Staff members told us they received full support after an incident, including seeking medical advice if needed, a debrief meeting and opportunities for discussion in team meetings.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
The provider must ensure that the environment is clean.

Action the provider SHOULD take to improve
The provider should continue in its efforts to ensure that staff working on Fairfax ward receive physical intervention training which is appropriate to the patient group.

The provider should ensure medicines are managed safely.

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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met: Areas of the ward, including the quiet lounge, temporary lounge, and some bedrooms, were not clean and smelt unpleasant and of urine. Some of the easy chairs, the walls, carpets and duvets were stained and required cleaning. In the bathrooms the floor to wall seal was coming away from the wall in some places, and the shower chairs were stained and staff had not cleaned the underneath of them. A patient's mattress was wet with urine underneath, which staff did not notice whilst making the bed. This was a breach of regulation 15 (1) (a)