Cygnet Hospital Colchester

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

Overall summary

We did not rate wards for people with learning disability or autism or long stay/rehabilitation mental health wards for working age adults at this focused inspection. We found the following areas of good practice:

- The provider had reduced the risk of patients accessing the security fence and roof by improving the physical environment of the garden area on Oak Court. Staff completed risk assessments for patients and updated these regularly, including specific risk assessments in relation to accessing the security fence and roof.
- The provider deployed sufficient staff to maintain the safety of patients on all wards and to undertake enhanced observations for patients. Managers ensured they offered regular breaks to staff. The provider had established systems to provide accurate information about staffing levels and monitor this across the service.
- The provider had reviewed the paperwork for allocating enhanced observations and monitored how managers allocated staff to work with patients. The provider had established a clear protocol and rationale to explain why staff worked outside the therapeutic engagement and observation policy on Larch Court to meet the needs of patients with autistic spectrum disorders. Managers had also applied this rationale to some of the staffing arrangements on Oak Court where staff supported some patients separately due to the closure of another ward.
- The provider had ensured that staff admitted patients to the service within their referral and admissions criteria.

However, we found the following issues that the provider needs to improve:

- The therapeutic engagement and observation policy did not always accurately reflect the working arrangements across the service. On some occasions, managers recorded that they had allocated staff to enhanced observations for longer than stated in their policy.

Summary of findings

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Wards for people with learning disabilities or autism; Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Cygnet Hospital Colchester

Cygnet Hospital Colchester is an independent hospital providing specialist services for adults with learning disabilities and/or autism and additional complex needs, and adults with a diagnosis of mental illness or disorder who require specialist care. Patients may be detained under the Mental Health Act 1983. The provider for this location is Cygnet Learning Disabilities Limited and the corporate provider is Cygnet Health Care.

The hospital has undergone changes and has closed a number of its wards whilst building work is carried out. It currently accommodates up to 25 people on three wards:

- Oak Court has 12 locked rehabilitation beds for men with learning disabilities or autism.
- Larch Court has four beds for men with autistic spectrum disorder (ASD) and challenging behaviour.
- The Flower-Adams service currently has nine beds for women with personality disorder. This service is not for people with a learning disability or autism. On completion of building works, the Flower-Adams service will have 20 beds.

The Joy Clare activity centre provides additional opportunities off site for the learning disability wards. Managers told us that the service also plans to open a mental health service for men on completion of building works.

At the time of the inspection there were 11 patients in the service. The manager of the service is currently registering with the Care Quality Commission and there is an identified controlled drugs accountable officer.

This location is registered with the Care Quality Commission to provide 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 previously carried out a comprehensive inspection of this location on 21, 22 and 27 February 2017 when it was rated as requires improvement. The safe, effective and well-led domains were rated as requires improvement and the caring and effective domains were rated as good. Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified for regulation 12, safe care and treatment.

A further focused inspection was carried out on 6 July 2017. Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified for:

- Regulation 10, dignity and respect;
- Regulation 11, need for consent;
- Regulation 12, safe care and treatment; and
- Regulation 15, safety and suitability of premises.

The Care Quality Commission carried out a further focused inspection of this location on 29 November 2017, 4, 15, 18 and 19 December 2017 and 7 January 2018. Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified for the following regulations:

- Regulation 9, person-centred care;
- Regulation 12, safe care and treatment;
- Regulation 13, safeguarding service users from abuse and improper treatment;
- Regulation 17, good governance; and
- Regulation 18 staffing.

The provider sent the CQC their action plans to address these.

Warning Notices were issued in respect of regulation 12, safe care and treatment, regulation 17, good governance and regulation 18, staffing.

Summary of this inspection

Our inspection team

The team that inspected the service comprised three CQC inspectors and a specialist adviser.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at this location.

Why we carried out this inspection

We inspected this service to see if the provider had made improvements since the last focused inspection, when Warning Notices were issued against the provider for the following regulations:

- Regulation 12, safe care and treatment. We were concerned that two patients had accessed the security fence and the roof of the hospital and had absconded from the service.
- Regulation 17, good governance. We were concerned that the service did not have systems in place to ensure they admitted patients appropriately, conducted observations safely and in line with policy and had accurate information about staffing numbers on wards.
- Regulation 18, staffing. We were concerned that there were not sufficient numbers of staff to support patients safely.

Since the last inspection, the service had undergone a significant reconfiguration, detailed above. The hospital was therefore in a period of transition; planned development work had not yet been completed and the numbers of patients had reduced. At the time of the inspection there were 11 patients in the service, across three wards. Whilst we found the provider had made significant improvements to address the concerns raised, due to the number of patients and the partial reconfiguration of the service, we could not be fully assured these improvements would be sustained when the service is fully operational. We will therefore review further the concerns identified in the Warning Notices at the next planned inspection when the provider's new services will be more established.

How we carried out this inspection

At this inspection, we reviewed the concerns we had raised with the provider in the Warning Notices to see if they had made improvements to the service.

On this inspection we have focused on asking the following questions:

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

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with two patients who were using the service;
- spoke with the hospital manager and managers for two of the wards;
- spoke with 10 other staff members; including nurses and support workers;
- looked at nine care and treatment records of patients and;
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with two patients. They said that staff did not cancel activities and leave, although these might sometimes be delayed. Staff offered plenty of activities and supported patients to go into the local community regularly.

One patient said that the ward was calm and that rather than use physical interventions, such as restraint, most of the staff talked to the patients to resolve issues.

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 rate wards for people with learning disability or autism or long stay/rehabilitation mental health wards for working age adults at this focused inspection. We found the following areas of good practice:

- The provider had undertaken a thorough risk assessment of the garden area on Oak Court and had taken action to reduce the risk of patients accessing the security fence and roof.
- The provider had completed risk assessments for some patients to mitigate this risk further.
- The provider deployed sufficient staff to maintain the safety of patients on all wards.
- The provider deployed sufficient staff to undertake enhanced observations for patients and gave regular breaks to staff.
- Staff completed risk assessments for patients and updated these regularly.

However, we found the following issue that the provider needed to improve:

- On some occasions, managers recorded that they had allocated staff to individual enhanced observations for longer periods than stated in their policy.

Are services well-led?

We did not rate wards for people with learning disability or autism or long stay/rehabilitation mental health wards for working age adults at this focused inspection. We found the following areas of good practice:

- The provider had reviewed the paperwork for allocating staff to individual enhanced observations and monitored how managers allocated staff to work with patients.
- The provider had established a clear protocol and rationale to explain why staff worked outside the therapeutic engagement and observation policy on Larch Court. Staff were allocated much longer periods of time on this ward to meet the needs of patients with autistic spectrum disorders. The provider had also applied this rationale on Oak Court as an interim measure due to the closure of another ward for patients with autistic spectrum disorder.
- The provider had ensured they admitted patients to the service within their referral and admissions criteria.

Summary of this inspection

- The provider had established systems to provide accurate information about staffing levels and monitor this across the service.

However, we found the following issue that the provider needed to improve:

- The therapeutic engagement and observation policy did not always accurately reflect the working arrangements across the whole service.

Wards for people with learning disabilities or autism

Safe	
Well-led	

Are wards for people with learning disabilities or autism safe?

During this inspection, we focused on specific aspects of the safe domain to assess that the provider had addressed the issues we raised with them.

Safe staffing

- The provider had a protocol in place to calculate safe staffing levels for each ward. We looked at Oak Court, Larch Court and the new Flower-Adams service. On each ward staffing levels met this protocol or exceeded it. The provider had ensured that there was a range of registered and unregistered nursing staff to support patients. We looked at staffing for the previous three months and found the provider maintained safe staffing numbers across all wards. The provider ensured there were enough staff to give regular individual time to patients and ensured they did not cancel activities and leave. Staff said that they were able to offer activities to patients. The two patients we spoke with said that staff took them walking, shopping and played football with them.
- The provider had deployed sufficient staff to ensure that staff observed patients safely, carried out physical interventions when needed, and ensured staff had regular breaks. Managers requested additional staff when needed.
- The provider did not use any agency staff at the time of the inspection.

Assessing and managing risk to patients and staff

- The provider had mitigated the risk of patients accessing the roof of Oak Court. The provider had completed environmental risk assessments in relation to the wards. This included a specific risk assessment for the garden area on Oak Court which addressed concerns raised at the last inspection. The provider had made improvements to the outside area by reducing hand and foot holds, removing ropes and cables and making modifications to the windows, fence, gates and a door into the ward. The provider had removed tree branches to reduce the risk of patients climbing them to access the roof or fence. They had also moved a minibus away from the fence to ensure that patients could not use it as an aid to abscond from the hospital. There had not been any further examples of patients accessing the security fence or roof since 30 November 2017. We looked at incident forms which confirmed this.
- Staff completed risk assessments for some patients in relation to reducing the risk of patients climbing the security fence and accessing the roof on Oak Court. However, staff had not done this for all patients on the ward. The provider stated that they would complete risk assessments for patients of above average climbing ability. We looked at four patient records on Oak Court. Staff had completed risk assessments for two patients. We found these risk assessments mitigated the risk of access to the roof for these patients. Systems were in place to ensure staff supported and observed patients when accessing the garden areas. Patients had free access to garden areas. However, we looked at five records for patients on other wards. One patient had a known history of absconding by climbing and jumping. There were no individual risk assessments in place for this. However, staff mitigated these risks by close observations for this patient.
- Staff completed risk assessments for each patient and reviewed and updated these appropriately. We looked at nine patient records across the whole service.

Are wards for people with learning disabilities or autism well-led?

During this inspection, we focused on specific aspects of the well-led domain to assess that the provider had addressed the issues we raised with them.

Good governance

- The provider had put systems in place to assist them to monitor enhanced observations. The provider's therapeutic engagement and observation procedure stated that staff undertaking observation within

eyesight should do so for no longer than one hour followed by a break. This was in recognition of the potential difficulty in maintaining concentration for more than this time.

- Managers had reviewed allocation forms for enhanced observations; they divided into hourly periods to reflect the provider's policy.
- The provider had produced a protocol for Larch Court which provided a rationale for this ward to work outside of the therapeutic engagement and observation policy and procedure. This was to ensure staff could provide consistency and continuity to patients with autistic spectrum disorder. This protocol also recognised there were differences between enhanced individual observations and individual support. Staff supported patients on Larch Court constantly throughout the day. Observation records showed that staff regularly worked the entire shift with one patient. However, staff stated that they did get regular breaks throughout this period.
- On Oak Court, there were also examples of staff providing individual support for 12 hours with the same patient. This was due to staff supporting some patients separately on this ward, due to temporary closure of their parent ward for refurbishment. These patients also had a diagnosis of autistic spectrum disorder and benefitted from having the same staff to support them for longer periods. Staff stated that managers offered them regular breaks during their shift.
- Where other patients required individual enhanced observation, managers rotated staff so they did not work with the same patient for long periods of time. On occasions, managers allocated staff to work for more than one hour with the same patient. However, staff stated they took breaks when needed and when they worked for longer periods it was because they were supporting a patient outside the hospital or because the observations were not intensive or demanding.
- The provider had not admitted patients outside of their exclusion criteria. The provider had reviewed the admissions criteria for Oak Court to reflect its current client group. The manager stated that staff would review admissions criteria as new services opened. We looked at referral and admission paperwork for three patients. In all cases, the provider had admitted patients in line with its policy. The manager stated that the company's referral and admissions procedure remained the same. However, the manager told us that they would carry out additional assessments where there were concerns about an individual's suitability for the service. However, due to the number of patients and the partial reconfiguration of the service, we could not be fully assured that the concerns we previously raised with the provider would be sustained when the service was fully operational.
- The provider had established effective systems to monitor staffing arrangements across the service. Rotas reflected actual staffing levels for each ward and highlighted gaps due to absence. This meant they were aware of any short staffing, could mitigate this risk and maintain safe staffing levels. The provider had also put in place a system to track the movement of staff from one ward to another. We looked at rotas over a three-month period which demonstrated that the provider maintained safe staffing levels.

Leadership, morale and staff engagement

- Morale was high across the service. Staff told us that they had received training for the new service and felt confident and supported to take on this new work.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that the therapeutic engagement and observation policy accurately reflects the working arrangements across the whole service.