Cygnet Health Care Limited

Cygnet Joyce Parker Hospital

Inspection report

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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 carried out a focused inspection of Mermaid ward after staff raised concerns with us. At the time of our inspection the service had made some improvements in respect of these concerns.

We did not rate this service at this inspection.

The service did not always have enough staff to ensure there were the right number according to the hospital's staffing requirement.

Staff were new to their roles and not all staff were confident they had enough staff or experience to respond to emergencies or incidents. There was a period of increased incidents on the ward where the ward was chaotic. This resulted in an increase of assaults on staff, a rise in patients self-harming, and security breaches took place.

The ward environment was not always robust enough. There were patients who had damaged aspects of the ward and had caused harm as a result of this.

There were some effective governance processes, but these were not consistent. For example, there were lapses in management of the staff rota and staff inductions had not always covered all key areas. This meant not all staff were well prepared for their roles.

However:

The ward environments were clean, and staff followed policies and processes to keep staff and patients safe from COVID-19. Staff regularly assessed patients' risk and recorded this, they minimised the use of restrictive practices and followed good practice with respect to safeguarding. Staff reported incidents and learned from these.

Senior leaders understood the service. Senior leaders acted following the increase in incidents and whistle blowing concerns. Staff were able to give feedback and knew how to raise concerns.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	**Inspected but not rated**	We did not rate this service as we did not look at all of the key lines of enquiry in the areas we inspected. The summary of this service can be found in the overall summary section.

Summary of findings

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Summary of this inspection

Background to Cygnet Joyce Parker Hospital

We carried out this focused inspection of Mermaid ward because during a Mental Health Act visit some families raised concerns and we had also received whistle blowing concerns. Mermaid ward was the only ward open at this time.

Before the inspection we received four whistle blowing concerns and one more concern was raised after our inspection. The main concerns were about low levels of staff, staff and patient safety, low levels of staff confidence, insufficient support from leaders and staff not always being sufficiently skilled, trained and confident for the job. Two staff had left their new roles due to these concerns. Two of the whistle blowers identified themselves, three of the whistle blowers chose to remain anonymous.

Cygnet Joyce Parker hospital is provided by Cygnet Healthcare and provides care and treatment for children and adolescents between the ages of 12 and 18.

The hospital provided the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Treatment of disease, disorder or injury

The hospital has two wards:

Mermaid ward, a Child and adolescent Psychiatric Intensive Care Unit, this ward has 10 beds.

Dragon ward, a General Adolescent Unit, this ward has 12 beds.

Mermaid ward opened on 3 November 2020 and Dragon ward opened on 15 February 2021.

Children and young people between the age of 12 and 18 could access the service and there was an Ofsted registered school onsite. The school opened in January 2021.

The hospital had not been inspected before and had previously been known as Cygnet hospital Coventry. This hospital had been closed by Cygnet Healthcare in July 2020 and reopened as Cygnet Joyce Parker on 15 October 2020. Cygnet hospital Coventry had last been inspected in June 2020 and was rated as inadequate by the CQC.

At the time of our inspection there were six patients on Mermaid ward.

What people who use the service say

Prior to our inspection we spoke to the families and carers of all the children on Mermaid ward. The feedback from families was mixed. We spoke to nine family members. Four families were happy with the care that the hospital provided and were positive about the way their family members were cared for. There were concerns raised by two families about

Summary of this inspection

their childs' self-harm. One of these parents raised concerns about the ward environment not being safe for their child who had been able to damage the environment to self harm. Another parent raised concerns about their son who was on section 17 leave. We followed up these concerns with the hospital directly and the hospital had taken appropriate action. Two more parents told us that the hospital did not always communicate well with them.

On the day of our inspection there was one patient who wanted to speak to us. This patient was happy with the care they received and spoke very positively about staff and specifically their named nurse. They told us they were cared for and treated well and that they had made progress in their treatment.

We left comment cards for patients to fill in, but the provider told us that patients had not wanted to complete these.

The two commissioners we spoke to provided positive feedback about the service and did not identify any concerns.

How we carried out this inspection

This was a focused inspection and therefore our inspection activity looked at only part of the safe and well led key questions. This meant we did not look at all key lines of enquiry in each of these domains. We did not inspect the effective, caring and responsive domains.

Due to the COVID-19 pandemic, we conducted most staff interviews by telephone. Two inspectors carried out a site visit and one of the inspectors visited Mermaid ward. A further two inspectors and an inspection manager inspected remotely.

During this inspection, the inspection team:

- spoke with one patient who was being cared for by the hospital
- completed telephone and face to face interviews with 22 staff members including doctors, a social worker, psychologists, an occupational therapist, nurses and support workers
- looked at the quality of the hospital environment
- looked at four patients' care and treatment records
- completed interviews of two senior managers, the registered manager and hospital manager
- spoke with two commissioners who had placed patients in the hospital
- looked at a range of policies, procedures and other documents relating to the running of the hospital.

Areas for improvement

Action the service MUST take that is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by 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:

We told the service that it must take action to bring services into line with two legal requirements. This action related to the service;

Summary of this inspection

- The provider must ensure that there are enough staff to meet the staffing requirements set out by Cygnet Joyce Parker hospital and that staff are suitably skilled and confident, keep the ward safe and ensure incidents are reduced. **HSCA Regulation 18 (1) Staffing.**
- The service must make sure the ward is robust and safe so that patients are unable to damage the environment to cause harm to themselves or others. **HSCA Regulation 12 (2) d Safe Care and Treatment**

Action the service SHOULD take to improve:

- The service should ensure there are enough activities and structure for patients to engage in during evenings and weekends.
- The service should ensure that there is a thorough induction and training available so that all staff feel confident and knowledgeable for their roles.
- The service should ensure there is clear signage to indicate where the female lounge is.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	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

Inspected but not rated

Child and adolescent mental health wards

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Child and adolescent mental health wards safe?

Inspected but not rated

We did not rate safe at this inspection. We found

- There were not always enough staff on shift to meet the staffing requirements put in place by Cygnet Joyce Parker hospital. We reviewed staffing between 7 February and 19 February 2021. During this period there were a total of 26 shifts and on 17 of the shifts staffing numbers were below those set out as required. Staff told us the number of enhanced therapeutic observations and the impact of emergency and other medical appointments off the ward meant that there were fewer staff available for general ward tasks. Not all staff felt confident that they had enough staff available when emergencies arose. Staff said this was more of a concern at weekends and in the evenings when the multidisciplinary team staff did not work. Between the 12and 15 February 2021 staffing had not met the hospital's staffing template. It was during this time period when a higher number of incidents had taken place on the ward.
- At our inspection we reviewed staffing and saw the hospital had acted and had increased staff, with the use of agency and bank staff and had made changes to the staff rota. In addition, on the 15 February another ward at the hospital had been opened. This meant staff from both Mermaid and Dragon ward were able to support each other in an emergency.
- Some staff said that there was not enough activity for patients at the weekends and in the evening. The hospital had decided to employ a new activity worker to ensure patients on the ward had enough to do.
- Staff knew the patients and most staff had received basic training to keep patients safe from avoidable harm. Staff training compliance was at 78% on average.
- Leaders told us that over a third of the staff team had not worked with children and young people or in a similar ward environment before. Most staff had completed a full induction, but there had been two induction programmes including the most recent one which had been shorter than planned and this meant staff from this induction had not been as well prepared for their roles. Two new members of staff had left their new roles after a shortened induction. They said they did not think the ward was safe and one of the staff was assaulted on their first day when they were shadowing staff to learn about the ward.
- The ward environment was not always safe. Patients on the ward had been able to harm themselves by damaging some of the fixtures and fittings. The provider had carried out relevant repairs, but the environment was not as robust as it needed to be for the patients who were on the ward.
- We reviewed incidents from the 1 January until the 24 February 2021. There had been 365 incidents during this 55-day period, 35 of which were recorded as 'moderate.' The other incidents had been recorded as 'minor' or 'no harm.' Between the 12 February and 15 February 2021, a higher number of incidents had taken place. There had been 68 incidents, which was 19% of the total incidents reviewed and nine of these incidents were classed as 'moderate' which was 25% of the total moderate incidents. Incidents included self harm, breaches of security and assaults on staff. Staff described a chaotic and challenging few days. Staff and leaders described several reasons for this increase, reviewed the incidents and put an action plan in place to avoid this happening again.

However;

Inspected but not rated

Child and adolescent mental health wards

- All wards were clean and well-furnished. There were policies and processes in place to keep patients and staff safe from the COVID-19 pandemic and we saw that staff followed good infection control principles.
- We reviewed care records and saw staff assessed risks to patients well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a safeguarding lead.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Staff and patients completed debriefs after incidents.
- At the time of our inspection there was no signage to indicate where the female only lounge was. Staff told us patients had removed the sign. After our inspection the ward provided us with evidence that the sign had been replaced.

Are Child and adolescent mental health wards well-led?

Inspected but not rated

We did not rate well-led at this inspection. We found:

- Our findings from the safe key question demonstrated that some effective governance processes were in place, but this was not consistent:

There were regular and thorough clinical governance meetings where multidisciplinary staff met and reviewed governance, this included restrictive practice, incidents and performance. Supervision and meetings took place overall staff were up to date with their supervision.

However, not all governance was effective. There had been issues with staff rotas and this meant that staffing had not always met the staffing requirement set by the hospital. In addition, due to the COVID-19 pandemic induction sessions did not always include all planned elements and had been shortened. Should we add in here not taking action following the incidents as well as although they reviewed I am not clear that they took action directly or until we raised with them?

Cygnet Joyce Parker was a new hospital, and the staff team were new to the hospital. Leaders told us over a third of the staff did not have experience working with young people in a hospital environment. Staff told us that not all staff were confident and comfortable to manage incidents on the ward. The hospital leaders had put in place support for staff and planned to offer additional training that was specifically relevant to patients cared for by the service.

However:

- Senior leaders had the knowledge and experience to perform their roles, they had a good understanding of the service, and at inspection staff told us they were visible in the service and approachable for patients and staff. Senior leaders acted in response to the increased incidents that took place on Mermaid ward and in response to whistle blowing that was raised directly with the Care Quality Commission.
- Most staff told us they felt supported and valued. Although not all staff had felt listened to in respect of staffing concerns, staff said this had now improved. Most staff told us when they raised concerns leaders responded to them. Staff had opportunity and knew how to give feedback and raise concerns without fear of retribution and there was

information about how to whistle blow available for staff. The organisation's Freedom to Speak up Guardian had visited the hospital since the whistle blowing concerns had been raised with us and staff had not raised any further concerns. Following the whistle blowing, senior leaders had spoken to all staff to ask them their view about the concerns raised.

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 18 HSCA (RA) Regulations 2014 Staffing **There were not always enough staff to meet staffing requirements set by the hospital. Not all staff were suitably skilled and confident for their roles.**

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 **The ward environment was not always robust and safe for patients.**