Cygnet Hospital Sheffield

Quality Report

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Date of inspection visit: 23-24 May 2019
Date of publication: 23/07/2019

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	

Overall summary

This was a focused inspection of one ward. The inspection focused on specific issues that had led us to undertake the inspection. These were relevant to the key questions of 'is the service safe' and 'is the service effective'. The inspection did not impact on the current rating of this location.

We found the following areas of good practice:

- Staff assessed and managed risks to patients and themselves 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 recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team
- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed and updated as needed through multidisciplinary discussion.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with a range of skills needed to provide high quality care.

We found the following areas the hospital needs to improve:

- Risk management plans and care plans were brief and did not reflect the level of support and interventions evidenced within the patients' contemporaneous notes.

Summary of findings

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Cygnet Hospital Sheffield

Services we looked at
Child and adolescent mental health wards.

Summary of this inspection

Background to Chgnet Hospital Sheffield

Cygnet Hospital Sheffield is an independent mental health hospitalproviding child and adolescent mental health services for male and female adolescents aged between 12 and 18 and low secure services for women over 18. The hospital has capacity to provide care for 55 patients across four wards. These are:

- Pegasus Ward: 13 bed mixed sex acute ward for children and adolescents
- Unicorn Ward: 10 bed mixed sex psychiatric intensive care unit for children and adolescents
- Griffin: 15 bed mixed sex low secure unit for children and adolescents. At the time of the inspection the service had restricted admissions to 9 patients to enable a review of the ward following the opening of the ward in April 2019.
- Spencer ward: 15 bed low secure adults ward for female patients.

The hospital had one registered manager for all four wards. The hospital is registered to provide the following regulated activities:

- assessment or medical treatment for persons detained under the 1983 Mental Health Act
- diagnostic and screening procedures
- treatment of disease, disorder or injury.

This inspection was a focused inspection of Griffin ward following concerns about patient safety on the ward since opening in April 2019. Following the inspection, we were satisfied that the hospital had acted to resolve concerns and that systems and processes were in place to maintain the safety of patients on the ward including the hospitals internal review of the ward's progress since opening.

We previously undertook a comprehensive inspection of Cygnet hospital Sheffield in August2017. Following that inspection, we rated the hospital as requires improvement overall and issued the provider with three requirement notices. These related to:

- Regulation 9 HCA (Regulated Activities) Regulations 2014: Person-centred care.
- Regulation 16HCA (Regulated Activities) Regulations 2014:Receiving and acting on complaints.
- Regulation 17HCA (Regulated Activities) Regulations 2014:Good governance.

In September 2017, we carried out an unannounced focussed inspection on the acute adolescent ward, Peak View in response to two significant incidents. The inspection was not rated but the provider was issued with the following breaches;

- Regulation 12HCA (Regulated Activities) Regulations 2014safe care and treatment.
- Regulation 17HCA (Regulated Activities) Regulations 2014good governance.

We carried out a further unannounced focussed inspection in December 2017 on both child and adolescents' mental health wards, because we had some concerns about patient safety. At that inspection, there were no regulatory breaches.

We completed a further focused inspection in July 2018 and found the provider had met the requirements in relation to regulations 9, person centred care, 16, receiving and acting on complaints, and 12, safe care and treatment and regulation 17, good governance.

Although the provider had made significant improvements, we were not able to change the ratings for this hospital because the inspection was focussed only on those specific areas which we required the provider to address following the inspections in August 2017 and September 2017.

Summary of this inspection

Our inspection team

Our inspection team consisted of a team leader, one inspector and one assistant inspector from the Care Quality Commission.

Why we carried out this inspection

We carried out this focused inspection in response to a whistleblowing and concerns about patient safety identified through our routine monitoring of the service since the ward opened in April 2019.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

During this inspection, we focused only on specific issues that had led us to undertake the focussed inspection. These were relevant to the key questions of 'is the service safe' and 'is the service effective'

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

During the inspection visit, the inspection team:

- visited Griffin ward at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with one patient who was using the service and one carer of someone using the service;
- spoke with senior managers for the service, the registered manager and the ward manager;
- spoke with five other staff members; including doctor, nurse, occupational therapist and social worker;
- looked at four care and treatment records of patients;
- looked at the Mental Health Act documentation for all patients and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

The people we spoke with told us the ward felt like a safe place, that staff were friendly and knew the patients well.

They said staff involved people in their care. Staff used de-escalation strategies well to manage situations only using restraint when necessary to prevent harm to patients.

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 found the following areas of good practice:

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves 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 recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.
- Staff and patients were offered the opportunity for de-brief following incidents and staff could take part in reflective practice sessions.

We found the following areas the hospital needs to improve:

- Risk care plans did not reflect all the risks identified in the initial risk screening tool. Although contemporaneous notes evidenced interventions were in place to address these risks.

Are services effective?

We found the following areas of good practice:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed and updated as needed through multidisciplinary discussion.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with a range of skills needed to provide high quality care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

We found the following areas the hospital needs to improve:

- Care plans were brief and lacked detail of the support and interventions provided by staff as evidenced within the contemporaneous care records.

Detailed findings from this inspection

Child and adolescent mental health wards

Safe	
Effective	

Are child and adolescent mental health wards safe?

Safe and clean environment

Safety of the ward layout

The ward complied with guidance on eliminating mixed-sex accommodation, there were separate male and female corridors providing en-suite bedrooms with a toilet and shower. The ward was clean, well equipped, well furnished, well maintained and fit for purpose. There were no potential ligature anchor points, staff had easy access to alarms and patients had easy access to nurse call systems within bedrooms and communal bathrooms. There was an up to date environmental risk assessment which included an assessment of ligature risks. The layout of the ward included some blind spots which staff were aware of and were mitigated through observations and the use of CCTV in communal areas. The service completed a regular spot check audit of the CCTV and would review footage following incidents. A member of staff was allocated to complete observations of communal areas for each shift and individual patient allocations were completed based on patients' individual level of need.

Seclusion room

The Seclusion room allowed clear observation and two-way communication. It had a toilet and a clock was visible from the room. Anti-tear bedding was available in the seclusion suite to be provided if necessary.

The area of the ward used for long term segregation was at the end of the male corridor and could be closed off from the rest of the ward to provide an en-suite bedroom, a lounge area and access to an outside space.

Clinic room and equipment

The clinic room was clean, fully equipped, and were seen to have accessible resuscitation equipment. A recent visit by NHS England had identified the door between the staff office and the clinic room did not close properly. This issue had been resolved and the door effectively closed.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. Including training in de-escalation and restraint which had a compliance rate of 84%. Staff had also received training in life support and the use of an automated external defibrillator. 89% of eligible staff had completed basic life support including automated external defibrillator training and 67% of eligible staff had completed intermediate life support training including automated external defibrillator.

The service had enough nursing staff to keep patients safe. The service had developed a staffing matrix based on the Royal College of Psychiatrists quality network for inpatient child and adolescent mental health services quality standards. The matrix identified the minimum staffing levels for the ward based on patient numbers. The manager told us they used the matrix to plan the core rota and would increase staffing levels based on individual patient need and level of observations. At the time of the inspection the minimum staffing for the ward were two nurses and four support workers during the day and one nurse and four support workers during the night. This ensured there were enough staff to carry out physical interventions safely, for example, observations, restraint and seclusion.

Senior managers acknowledged there had been some difficulties when the ward opened, many of which had been specifically associated to the complexity of the patient group on the ward at the time. They told us the ward environment had settled following further admissions which had balanced the dynamics on the ward. Managers told us the decision had been made to suspend admissions at nine patients whilst the service completed an initial six-week review which was ongoing at the time of the inspection. The review allowed the service to identify any areas of development and develop an action plan to address these whilst enabling ongoing recruitment to be completed ensuring there would be enough staff to increase the core staffing levels once more admissions were accepted.

Child and adolescent mental health wards

The consultant psychiatrist appointed prior to the ward opening had resigned shortly after the ward opened. At the time of the inspection there was a locum consultant in post who had worked at the hospital previously on the adolescent psychiatric intensive care unit. The consultant was aware of the needs of the patient group and since commencing in the role had spent time getting to know the patients individually and reviewing their Mental Health Act documentation and prescription records. The service was in the process of recruiting a permenant consultant and speciality doctor for the ward. The hospital had an on-call rota to provide medical cover and a doctor was available to attend the ward quickly in an emergency.

Assessing and managing risk to patients and staff

We reviewed four care records, all contained risk assessments in the form of an initial risk screening tool and a risk management care plan. However, it was noted not all risks identified within the risk screening tool were always reflected within the risk management care plan. Although, there was evidence within the contemporaneous notes that staff were aware of and managing these risks. There was evidence that following incidents risks were discussed within the multidisciplinary ward round and risk assessments reviewed and updated. Incident records demonstrated that Staff used restraint and seclusion only after attempts at de-escalation had failed.

There was a daily multidisciplinary ward handover where staff reviewed patients' presentation over the previous 24 hours. There was a daily hospital risk meeting attended by the hospital management team, ward managers or a ward clinical team leader from each ward, the positive and safe lead for the service and appropriate multidisciplinary team members. The meeting enabled hospital managers and the positive and safe lead to be aware of any incidents, risks and safeguarding concerns across the hospital and to provide support to ward staff where necessary.

Staff we spoke with were aware of individual patient risks and care plans were in place to prevent or reduce risks. Psychology staff worked with patients to develop an individual formulation which included an individual positive behaviour support plan identifying individual triggers, distraction and de-escalation techniques.

Where patients presented with an increased risk staff would manage these using observations in line with the hospitals observation and engagement policy. Throughout the inspection we saw staff positively engaging with patients who were subject to increased observation levels. Staff were seen to be sitting with patients, talking and playing games with them. Some staff were seen to be sitting on the floor sharing a magazine with one patient who had chosen to sit on the floor in the communal lounge.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. At the time of the inspection 84% of the staff team had received training and the remaining staff were new starters who were scheduled to attend. Staff told us they made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Incident records demonstrated there had been 25 instances of restraint between the 1 May 2019 and the 24 May 2019 compared with 65 instances of restraint during April 2019.

Patients had specific care plans for restrictive interventions including seclusion and long-term segregation which included preferred support and items they would like to take with them for example, a digital music player or a book.

The service employed a positive and safe lead whose role was to support staff in maintaining least restrictive practises. The positive and safe lead completed regular audits of all incidents of restraint, seclusion and long-term segregation. Where concerns were identified these would be addressed either with specific individuals or with the whole team. For example, the recent audit identified issues with the terminology being used in seclusion records. A training session had been developed including anonymised examples from the records to support staff to produce more appropriate and descriptive records.

A system was in place where the positive and safe lead received a notification when incidents of seclusion commenced. They would attend the ward and review the situation with ward staff and provide advice and guidance on the situation to ensure incidents of seclusion were for the shortest time possible.

We reviewed a sample of the seclusion records for the ward and found these to be well organised, demonstrating

where all the necessary observations and reviews were required. The records we reviewed were completed fully and demonstrated all reviews had occurred in line with the Mental Health Act.

During the inspection no one was subject to long-term segregation. We reviewed the records for the most recent incident of long-term segregation. The records were detailed and demonstrated reviews required under the Mental Health Act had been completed. There was a clear long-term segregation plan which included what the patient needed to achieve to enable them to return to the ward and a clear plan of how they would be reintegrated on to the ward. The patient we spoke with told us where patients had been segregated the staff would also discuss the reintegration with the other patients on the ward to ensure it was a smooth transition.

Staff access to essential information

Patient records were held on a secure electronic recording system which could be accessed by all staff employed by the service. Agency staff working on a longer-term contract could also be provided with an account to log on to the system. Agency staff working for shorter periods were made aware of patients needs through their ward induction and the staff handover. Key information was also recorded on observation and allocation records.

At the time of the inspection seclusion and long-term segregation records were completed on paper and then scanned on to the patients' electronic record system once these had been completed. However, the service was in the process of developing a system to enable these to be completed electronically and uploaded directly on to the system.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Staff and managers understood their responsibilities under the duty of candour, the incident reporting system prompted staff to identify issues which met the criteria and staff gave patients and families a full explanation if things went wrong.

Managers debriefed and supported staff after any serious incident. Staff could also access weekly reflective practice sessions facilitated by the psychologist where they could reflect on incidents.

Managers investigated incidents and provided staff feedback of the learning from incidents within team meetings, including identifying improvements to patient care.

Before the inspection concerns were identified that patients had not received a medical assessment following some incidents of self-harm. Staff told us the ward doctor would complete an initial assessment following an incident and where necessary patients were supported to attend the accident and emergency department for further investigation. During the inspection we reviewed the incident records for the ward which included references to patients receiving medical assessments following self-harm.

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

All patients had their physical health assessed soon after admission and reviewed during their time on the ward.

Staff developed care plans for each patient. Care plans were individual and reflected the needs of each patient and included a risk management care plan, a restrictive intervention care plan detailing patients' preferred approach should restrictive interventions be required and a physical health care plan including ongoing monitoring of patients physical health. However, in the four records we reviewed we found that care plans were brief and did not reflect the level of detail and support recorded within patients' contemporaneous notes. Managers advised us this had been identified as part of the six-week review of the ward and would be addressed within subsequent action plans.

Psychology and occupational therapy staff completed assessments following a patients' admission to the ward and developed individual plans based on patient needs. Patients received an individual psychological formulation which identified the group and individual therapeutic

approaches which would be beneficial to the patients. The plans also incorporated a positive behaviour support plan detailing individual trigger points and appropriate distraction and de-escalation techniques.

Skilled staff to deliver care

The ward staff included the full range of specialists recommended by the quality network for inpatient child and adolescent mental health services standards to meet the needs of the patients. This included consultant psychiatrist, speciality doctor, nurses, support workers, psychologist, occupational therapist, social worker, psychology assistant and occupational therapy assistant. Patients also had access to an activity coordinator who provided access to the services gym facilities and other health-based activities.

Staff working on the ward had completed both the providers induction and the child and adolescent mental health service induction. Managers told us staff who had transferred to the ward from the adult service which had closed in 2018 had worked on the child and adolescent wards for a period of six months to gain experience prior to the opening of the low secure ward.

Psychologists delivered a range of psychological interventions underpinned by a programme of dialectical behavioural therapy. Nurses, social worker, occupational therapist, support workers and medical staff had a minimum of dialectical behavioural therapy skills training with key clinical staff receiving more advanced training ensuring staff were able to support patients to utilise their coping strategies throughout their admission.

There was a daily ward multidisciplinary handover where the team met to obtain an update on the patients over the last 24 hours. The team had a weekly team meeting where broader issues including learning from incidents were discussed. There was a supervision structure in place to ensure all staff received access to clinical and managerial supervision and staff could access a weekly reflective practise session lead by the ward psychologist. Staff told us they felt supported by both the ward manager and the hospital manager who they could approach at any time.

Adherence to the MHA and the MHA Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them. Staff knew who the Mental Health Act administrator was and could access support and advice on implementing the Mental Health Act and its Code of Practice if required.

We reviewed four patient records all of which demonstrated patients had their rights under the Mental Health Act explained to them on admission and at regular periods through their admission.

Before the inspection we received a notification advising that a patient had been prescribed medication without the correct certificate of consent to treatment. We reviewed the Mental Health Act documentation for all patients and were satisfied that all detention paperwork was completed appropriately and that all patients had the correct certificate of consent to treatment

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- the provider should ensure risk management plans reflect the support and interventions provided.
- the provider should ensure care plans reflect the support and interventions provided.