Cygnet Hospital Bury

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We did not plan to rate the hospital at this inspection as it was a focused inspection of the safe and well led key questions for two wards. However due to the inspection findings we have rated the core service as good, with the well led key question as requires improvement.

At this inspection we rated the Forensic inpatient/secure wards as good because:

- The service provided safe care. Patients on Columbus ward felt safe and well supported. Staff assessed risk well.
- We reviewed all patients in seclusion across Madison and Columbus wards. The patients understood the reason they were secluded. Person centred seclusion management plans were in place for patients we reviewed in seclusion.
- Staff received a thorough induction to the service and safeguarding training levels were high for both Madison and Columbus wards.
- Managers completed an action plan to address areas of concern in relation to professional boundaries of staff and patients. During the inspection we saw changes that had been implemented including changes in the staff team on Madison ward.
- The previous ratings of good for the effective, caring and responsive key questions from the 2019 inspection still applies.

However;

- Patients on Madison ward had not felt safe. Staff did not have the training to care for patients with a personality disorder.
- Staff did not follow the recruitment and selection policies.
- There was limited governance or audit of the safeguarding procedures to ensure agreed actions were completed.
- There was limited oversight of the Mental Health Act requirements, resulting in detention of a patient expiring and hospital managers hearings not taking place when they should.

We will add full information about our regulatory response to the concerns we have described to a final version of this report, which we will publish in due course.

Summary of findings

Contents

Good

Cygnet Hospital Bury

Services we looked at

Forensic inpatient or secure wards;

Summary of this inspection

Background to Cygnet Hospital Bury

Cygnet Hospital Bury is an independent mental health hospital with 167 beds. Funding is primarily from NHS England specialist commissioners. There was a hospital director in post who was the registered manager. There was a controlled drugs accountable officer in post.

The hospital specialises in forensic inpatient and secure services for people with mental health needs including those who are deaf. In addition, the hospital provides child and adolescent services, including forensic inpatient secure services and psychiatric intensive care services, for patients aged 11 to 18.

This inspection was a focused inspection of the safe and well led key questions, following an increase in statutory notifications and concerns raised by patients, staff and commissioners. These concerns were regarding the professional boundaries of staff in one of the medium secure wards for men with a personality disorder.

The inspection focused on the following two wards:

- Madison ward, 13 beds for men with personality disorders, medium secure
- Columbus ward, 13 beds for men with personality disorders, medium secure.

The hospital was last inspected in April 2019. The service was rated as good in all key questions and we identified the following areas for improvement:

- Oversight of physical health and risk and the communication of this to staff at handover and within ward records was not fully in place.
- Provision of environments, information and care to meet the needs of patients with additional needs was not always in place.
- Agency staff did not always have access to necessary information regarding patients and did not always follow their care plans.

Our inspection team

The team that inspected the service comprised three CQC inspectors and a Mental Health Act reviewer.

Why we carried out this inspection

This inspection was a focused inspection of the safe and well led key questions, following an increase in statutory notifications and concerns raised by patients, staff and commissioners. These concerns were regarding the professional boundaries of staff in one of the medium secure wards for men with a personality disorder.

How we carried out this inspection

To explore the concerns raised with CQC we asked the following questions:

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

Before the inspection visit, we reviewed information that we held about the location and asked commissioners for information.

During the inspection visit, the inspection team:

- visited Madison and Columbus wards and observed how staff were caring for patients
- spoke with 10 patients who were using the service
- spoke with the general manager, registered manager and ward manager of Madison ward
- spoke with six other staff members; including doctors, human resources, nurses and support workers

Summary of this inspection

- received feedback about the service from three commissioners
- spoke with an independent advocate
- looked at four care and treatment records of patients and Mental Health Act documentation and seclusion records for three patients
- looked at six personnel files of staff and
- looked at a range of policies, procedures and other documents relating to the running of the service including complaints information.

What people who use the service say

We spoke with 10 patients. Patients on Madison ward said that it had been scary and unsafe on the ward, patients had been violent and aggressive, and they felt staff had not been able to manage the situations safely. Patients also told us belongings had gone missing and trading of belongings between patients had been taking place. Patients told us staff had not responded as quickly as they expected in relation to patients harming themselves and due to this, at times patients had needed to offer support to other patients. However, they told us with the recent changes of staff and some patients being nursed off the ward, they felt things had improved and felt safe at the time of the inspection.

In relation to professional boundaries, patients told us some female staff had become close to patients, blurring professional boundaries and they did not always wear appropriate clothing for the work environment.

Patients also told us that the ward was not delivering care as they would expect in a specialist ward for people with personality disorders, for example mutual expectations.

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?

Good

We rated safe as good because:

- Patients on Columbus ward felt safe and well supported. Staff assessed risk well.
- Risk assessments were detailed and current, including reviews following incidents.
- Seclusion management plans were in place for patients we reviewed in seclusion. The plans were person centred and reflected the plans for patients.
- Managers investigated incidents and shared lessons learned with the whole team and the wider service.

However:

- Patients on Madison ward had not felt safe on the ward, however they felt things had improved and they felt safe at the time of the inspection.
- On one occasion, staff did not follow safeguarding procedures when patients first alleged staff were breaching professional boundaries with patients. This was not reported to managers, safeguarding or investigated.

Are services effective?

Good

Not inspected at this inspection.

Are services caring?

Good

Not inspected at this inspection.

Are services responsive?

Good

Not inspected at this inspection.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- Staff did not follow the recruitment and selection policies regarding decisions of offer of employment and reference checks. Staff interviewing candidates had not received training in recruitment and selection.
- Staff did not have the training to care for patients with a personality disorder.
- Bank staff were not receiving supervision. This meant they had limited support and guidance in their role.
- There had been several ward managers and changes in staffing on Madison ward which meant patients and staff were not receiving consistent care, support and guidance.

Summary of this inspection

- Records were not contemporaneous. There were gaps in handover records and seclusion paperwork for patients on Madison ward.
- There was limited oversight and governance of the recruitment and selection process, safeguarding actions and Mental Health Act requirements.

However:

- Managers completed an action plan to address areas of concern in relation to professional boundaries between staff and patients. During the inspection we saw changes that had been implemented including changes in the staff team on Madison ward.
- The current leaders on Madison ward had reflected with the staff team what had not gone well and identified actions to improve these.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

We reviewed three patients from Madison ward who were being nursed in seclusion. They all understood the reason for seclusion. All had a seclusion management plan in place.

We found one patient was previously detained under section 47 of the Mental Health Act. The newly appointed Mental Health Act lead for the site had recently undertaken an audit of detention documentation where they found that renewal dates for the section 47 were incorrect and that the patient had been detained without the appropriate legal authority since November 2018. On discovering this, the Mental Health Act lead immediately alerted the responsible clinician who went to see the patient, explained the situation to them and placed them on a holding section 5(2) which can last for up to 72 hours. The application for detention was made by an approved mental health professional. The patient was then placed onto section 3 of the Mental Health Act. When we spoke with this patient, they understood the reason why they were secluded, were aware that their section had lapsed and understood their right of appeal.

Following a review of information requested from the service, we found 22 out of 27 patients had not had a hospital managers hearing in line with the Mental Health Act Code of Practice. Staff did not have an effective system to identify when a hospital managers hearing was required.

When reviewing the seclusion records, we found the following issues:

- Details of nurses who undertook nursing reviews were recorded but not always countersigned by the nurse in charge.
- Medical reviews were not always documented.
- There was no evidence of internal independent multi-disciplinary team reviews being completed.
- Scheduled multi-disciplinary team reviews were signed off by the responsible clinician but there was no record of who else from the multi-disciplinary team took part in the reviews.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Good	Good	Good	Good	Requires improvement	Good
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Good

Forensic inpatient or secure wards

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are forensic inpatient or secure wards safe?

Good

Safe and clean environment

Seclusion room

We spoke with three patients being nursed in seclusion. The three seclusion rooms we viewed did not have any safety hazards and the lighting was externally controlled with a dimmer for night time. The seclusion room doors were robust and opened outwards. The seclusion rooms allowed clear observation, had an intercom system so staff could communicate with patients and they had a toilet and a clock. The room temperature was monitored and controlled by staff in accordance with chapter 26 of the Mental Health Act 1983 Code of Practice, 2015.

Assessing and managing risk to patients and staff

Assessment of patient risk

The two risk assessments we reviewed used a recognised tool of START (Short-Term Assessment of Risk and Treatability) and HCR20 (Historical Clinical and Risk Management 20). Staff reviewed these regularly, including after any incident.

The risk assessments included patient's vulnerability from others and risk to others.

Management of patient risk

Patients told us that they had felt unsafe on Madison ward, telling us that patients had been violent and aggressive, and they felt staff had not been able to manage the situations safely. Patients also told us belongings had gone missing and trading of belongings between patients had been taking place. Patients told us staff had not responded as quickly as they expected in relation to patients harming themselves and due to this, at times patients had needed to offer support to other patients. However, they told us with the recent changes of staff and some patients being nursed off the ward, they felt things had improved and they felt safe at the time of the inspection.

In relation to professional boundaries, patients told us some female staff had become close to patients, blurring professional boundaries and they did not always wear appropriate clothing for the work environment. Team meeting minutes showed dress code was discussed at the meeting in February 2020.

Contact with CQC regarding Madison ward including statutory notifications in June and July 2020, included patients bulling other patients, staff disclosing confidential information, breaching professional boundaries between staff and patients, patients going absent without leave, staff not responding to incidents in a timely manner, patients self harming and requiring attendance at the emergency department.

Madison ward had several ward managers and changes in responsible clinicians in the last year, staff and patients told us this had been unsettling.

Team meeting minutes showed that staff identified patients that they were finding difficult to support. Staff were encouraged to access clinical and managerial supervision and reflective practice. Changes in presentation of patients and risk levels were recorded within handovers.

Use of restrictive interventions

Good

Forensic inpatient or secure wards

Seclusion

We reviewed three patients from Madison ward who were being nursed in seclusion. They all understood the reason for seclusion. All had a seclusion management plan in place.

When reviewing the seclusion records, we found that details of nurses who undertook nursing reviews were recorded but not always countersigned by the nurse in charge. Medical reviews were not always documented. There was no evidence of internal independent multi-disciplinary team reviews being completed. Scheduled multi-disciplinary team reviews were signed off by the responsible clinician but there was no record of who else from the multi-disciplinary team took part in the reviews. This was not in accordance with chapter 26 of the Mental Health Act 1983 Code of Practice, 2015.

When we requested to view the seclusion paperwork relating to an allegation made by a patient, staff could not find the paperwork.

Safeguarding

Staff received training on how to recognise and report abuse. Compliance levels for safeguarding eLearning level 2 training was Columbus ward 97% and Madison ward 87%.

Weekly safeguarding meetings took place with internal staff, managers, social workers and safeguarding leads. Safeguarding representatives from the local clinical commissioning group attended at least every four weeks. The safeguarding concerns were discussed within the meetings and any action taken recorded on the safeguarding log.

Concerns were raised by patients of staff not responding to incidents in a timely and appropriate manner. Records confirmed allegations of bullying. Safeguarding alerts were made by the hospital, statutory notifications were submitted, and observations were reviewed. Safeguarding plans were in place for patients where there was a safeguarding need.

A patient alleged to staff that a patient was having relationships with staff on 26 February 2020. This was recorded in the patients record however; no action was taken by the hospital to investigate this allegation. The hospital are now investigating this and the police have been informed as part of their investigation.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Senior managers submitted statutory notifications regarding safeguarding incidents to CQC.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Records confirmed incident reports had been submitted and referrals to other organisations including safeguarding had been made.

Staff told us that debriefs were offered following incidents and minutes confirmed reflective practice sessions were available for staff to attend.

Staff received feedback from investigation of incidents, both internal and external to the ward. Minutes confirmed these were discussed at team meetings where recommendations and changes in practice were noted.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good

We did not inspect this key question. The previous inspection rating of good from April 2019 still applies.

Good

Forensic inpatient or secure wards

Are forensic inpatient or secure wards caring?

Good

We did not inspect this key question. The previous inspection rating of good from April 2019 still applies.

Are forensic inpatient or secure wards responsive to people's needs?

(for example, to feedback?)

Good

We did not inspect this key question. The previous inspection rating of good from April 2019 still applies.

Are forensic inpatient or secure wards well-led?

Requires improvement

Leadership

The newly appointed ward manager for Madison ward had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Once aware of the allegations regarding breaching professional boundaries on Madison ward, senior managers followed their human resources processes including investigations and referrals to other agencies. However, when an allegation was made about staff breaching professional boundaries on East Hampton ward, the managers were not made aware and no investigation took place. Managers told us they were now completing a retrospective investigation.

Professional boundaries and therapeutic relationships were discussed with staff in team meetings to raise awareness and clarify their understanding of the expectations of their practice.

Culture

Staff on Madison ward did not feel respected, supported and valued. Discussions took place in team meetings and minutes noted that staff did not feel supported by colleagues; tasks were not shared equally, and there was inconsistency with staffing leading to a lack of consistency for patients. However; the new ward manager had identified these and was starting to address them.

Governance

There was limited oversight and governance of the recruitment and selection process, safeguarding actions and Mental Health Act requirements.

We reviewed six personnel files. Three of which were for the staff who had breached professional boundaries with patients. There were two examples of staff not following their organisations policies and procedures in relation to recruitment and selection and they did not follow safer recruitment. One of the staff members interview notes stated they were not appointable however; the hospital director overruled this. The hospital director explained they reviewed all unsuccessful applicants interview notes and may decide to offer candidates a post. There was no evidence of the decision-making process and this practice did not follow the Recruitment, selection and appointment of staff policy, Version cv1 Issued: 04/20 Review: 04/23 which states, "4.4. Written records of interviews and reasons for decisions made at each stage will be kept in line with the Company's Records Management and Data Quality policy." Records management and data quality policy, Version 01 Issued: 02/20 Review: 02/22.

Another staff member had a reference from their previous employer saying their contract had been terminated however; there was no action taken by the hospital regarding this and when explored with human resources, they said it should have been explored but was not. This does not follow the Recruitment, selection and appointment of staff policy, Version cv1 Issued: 04/20 Review: 04/23 which states "5.19. Receipt of 2 satisfactory professional references supplied on headed paper or a professional email which must cover a minimum period of 2 years."

Staff told us and records confirmed, that staff interviewing candidates had not received training in recruitment and selection. This meant there would be variable quality and consistency of the recruitment process.

Good

Forensic inpatient or secure wards

Records showed that of the three staff who had breached professional boundaries, two were bank members of staff and they had not had any supervision. The contracted member of staff had received regular supervision.

The weekly safeguarding log (where actions taken regarding safeguarding concerns were recorded) was not up to date at the time of inspection.

We found gaps in seclusion documentation, a patient's detention under the Mental Health Act had expired and 22 out of 27 patients had not had a hospital managers hearing prior to their detention under the Mental Health Act expiring. Staff did not have an effective system to identify when requirements under the Mental Health Act required review or action.

Staff had not received specialist personality disorder training for their role. We reviewed six personnel files of staff and requested training information for both wards. We found for the three staff where there were concerns about breaching of professional boundaries, they had all attended an induction which covered professional boundaries. However, they had not attended training in personality disorder. This meant they did not have the skills or knowledge to care for the presenting needs of patients. This does not follow national institute for health and care excellence guidance Antisocial personality disorder: prevention and management Clinical guideline Published: 28 January 2009 cg77 and Borderline personality disorder: recognition and management Clinical guideline Published: 28 January 2009 cg78.

Overall training compliance levels for personality disorder for Columbus ward was 59% and Madison ward was 35%. This was lower than at the last inspection in April 2019 with compliance levels of Columbus ward 87% and Madison ward 74%.

However; prior to the inspection, once the senior managers were aware of the concerns, they identified contributory factors and created an action plan to address these. At the inspection, we saw the actions were starting to be implemented, including additional staff for communal areas of the wards, changes within the staff teams and a review of the boundaries training.

Information management

We reviewed handover records for Madison ward and found several were missing and they were not completed in full. This meant there was not an accurate record of risks and events to handover to staff.

There were gaps in handover documentation for Madison ward. With eight handovers missing and three handover reports blank for March and May 2020, and handover reports missing for the eight days prior to the inspection for July 2020. This meant there was no record of information handed over to the staff team regarding patients for those dates.

Seclusion paperwork we reviewed did not follow all requirements of the Mental Health Act Code of Practice 2015 and staff could not locate the seclusion paperwork for a period of seclusion we requested.

Good

Child and adolescent mental health wards

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are child and adolescent mental health wards safe?

Good

We did not inspect this core service. The previous inspection rating of good from April 2019 still applies.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

We did not inspect this core service. The previous inspection rating of good from April 2019 still applies.

Are child and adolescent mental health wards caring?

Good

We did not inspect this core service. The previous inspection rating of good from April 2019 still applies.

Are child and adolescent mental health wards responsive to people's needs?

(for example, to feedback?)

Good

We did not inspect this core service. The previous inspection rating of good from April 2019 still applies.

Are child and adolescent mental health wards well-led?

Good

We did not inspect this core service. The previous inspection rating of good from April 2019 still applies.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must:

- Ensure staff working in the wards caring for patients with a personality disorder receive training relevant to their role including personality disorder.
- Ensure safer staff recruitment is followed, including following the providers policies and procedures.
- Ensure that all staff including bank staff receive regular supervision.
- Ensure there is audit and oversight of recruitment and selection processes, safeguarding requirements and Mental Health Act requirements.

Action the provider SHOULD take to improve

The provider should:

- Ensure that staff follow the Mental Health Act 1983: Code of Practice, 2015 in relation to seclusion reviews and document the reviews accurately.
- Continue with the review of the Mental Health Act documentation to ensure patients are detained with the appropriate legal safeguards in place.
- Ensure there are contemporaneous records for all patients including handover and seclusion documentation.