Cygnet Health Care Limited

Cygnet Hospital Beckton

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	Inadequate
Are services safe?	Inadequate
Are services caring?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

We undertook this focused inspection of the psychiatric intensive care unit and the ward for patients with learning disabilities, following four incidents of the alleged abuse of patients by staff. The service had informed us about these incidents.

We did not inspect the two wards for patients with a personality disorder during this inspection. Due to the overarching concerns we have about the hospital, we have suspended the ratings for personality disorder services.

Following this inspection, the Care Quality Commission took urgent enforcement action under section 31 of the Health and Social Care Act 2008. This means there are a number of conditions on the provider's registration, including that the hospital cannot admit any patients.

Letter from Professor Ted Baker, Chief Inspector of Hospitals:

'I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.'

We found:

- There had been four serious incidents between December 2020 and February 2021 which had raised concerns about the potential abuse and poor care of patients. The service had informed us about these incidents. One incident on the psychiatric intensive care unit and two incidents on the ward for patients with learning disabilities demonstrated unacceptable care practice. We saw evidence of unjustified restraint, the use of unauthorised restraint techniques, seclusion without appropriate safeguards and the apparent physical abuse of a patient by staff.
- We also randomly reviewed closed circuit television (CCTV) of a further two incidents on each ward. One of these incidents showed staff using unauthorised restraint techniques, which could have caused the patient significant harm. We had also been informed by the provider of a further incident where staff had locked a patient out in the ward garden for at least 20 minutes following an aggressive outburst. This happened in February 2021 when the weather was cold. CCTV footage was not available of this incident.
- Staff were not reporting serious incidents in line with the providers policies and procedures. Staff had not raised any of the above incidents of the use of unauthorised restraint techniques, seclusion without safeguards or alleged abuse, with managers. Managers learnt of three incidents following complaints from patients. The fourth incident was identified during an investigation into a patient injury. Having heard about the serious incidents described above, the management team had not reviewed CCTV of all other incidents on the wards in order to assure themselves of patient safety.

Summary of findings

- The closed-circuit television system was outdated. It was hard to review CCTV footage and images were not saved for 28 days. This meant that the provider might not be able to check the footage for serious incidents. Random reviews of CCTV footage by ward managers had been introduced but did not always take place as planned.
- Registered nursing and support worker vacancies led to the high use of agency staff who may not know the individual needs of the patients and how to meet their complex needs. The vacancy rate for registered nurses on the psychiatric intensive care unit was 66%, including two team leader posts. The vacancy rate for support workers on both wards was 50% although the number of support worker posts had recently been significantly increased to provide more permanent staff and consistent care. Also, the hospital manager had ensured there were very few registered nurse vacancies on Hansa Ward which is the ward for people with a learning disability. This was due to the specific needs of patients and the need for consistency of care. The manager also tried to use long-term agency staff where possible.
- Safe staffing levels were not always maintained on the wards. There were a number of shifts, over a period of three months, when both wards were below their current minimum safe staffing levels. In addition, the current staffing levels at night were not sufficient. Four staff were allocated to each ward at night. This included if one patient required continuous observation by staff. With staff breaks, this meant there were insufficient staff on the wards to keep patients safe at night if, for example, staff needed to restrain a patient.
- Senior leaders in Cygnet Health Care had not sufficiently addressed the ongoing challenges of the recruitment and retention of registered nurses. The number of vacancies of registered nurses in the hospital had been on the hospital risk register since November 2018. The hospital manager had repeatedly raised this with senior managers, including suggested solutions. The provider's senior managers had not taken effective action in a timely manner to address this.
- Ward managers and team leaders had not had access to appropriate leadership training to support them to carry out their roles to a high standard. This had been raised by the hospital manager since November 2019. The hospital manager had not been supported by senior managers to put these learning and development opportunities into place in a timely way.
- Feedback from patients, the patients' advocate, and relatives was mixed. They said staff could be rude, relatives were not always involved in patients' care and treatment, and some patients felt neglected and ignored. However, approximately half of the patients' relatives we spoke with were very positive regarding staff and their involvement in patients' care and treatment.

However, we also found:

- The hospital management team informed the local safeguarding team, CQC and the police, following incidents of alleged abuse.
- There had been a relaunch of the least restrictive practice programme to ensure patients did not have unnecessary restrictions placed upon them.
- The hospital manager had identified gaps in the care provided to patients. Regular night visits by hospital managers had been introduced.

Shortly after this inspection we received two further allegations of poor treatment of patients on the psychiatric intensive care unit and the ward for patients with learning disabilities. These allegations were referred to the local authority. One of the allegations was not upheld following a safeguarding investigation. A safeguarding investigation of the other allegation was ongoing when this report was published.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Inadequate 	
Wards for people with learning disabilities or autism	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Hospital Beckton

We undertook this focused unannounced inspection of two wards at Cygnet Hospital Beckton due to four incidents concerning the alleged abuse of patients by staff. The service had informed us about these incidents. As this was a focused inspection we only inspected some areas of Safe, Caring and Well-led.

At this inspection we inspected:

Hooper Ward - a 15 bed psychiatric intensive care unit for women. There were 10 patients on the ward at the time of the inspection.

Hansa Ward - a 13 bed ward for women with a learning disability or autism and mental health problems. There were 13 women on the ward at the time of the inspection.

The other two wards at Cygnet Hospital Beckton, New Dawn Ward and Upping Ward provided care and treatment for women with a personality disorder.

Cygnet Hospital Beckton is registered to provide Treatment of disease, disorder or injury and Assessment or medical treatment for persons detained under the Mental Health Act 1983.

There was a registered manager in post at the time of the inspection.

We last inspected Cygnet Hospital Beckton in November 2019. We rated the hospital Good for being Effective, Caring, Responsive and Well-Led and Requires Improvement for being Safe. Overall, the hospital was rated as Good.

How we carried out this inspection

The inspection team for this inspection consisted of five inspectors and an expert by experience. An expert by experience is someone who has used, or had a relative who has used, similar services.

This inspection involved a brief visit to the service. The remainder of the inspection was undertaken by videoconference and telephone due to COVID-19.

During this inspection, the inspection team:

- visited the service and observed how staff were delivering care to patients
- spoke with the registered manager
- spoke with the ward managers of Hooper and Hansa Wards, the clinical service manager and the operational director overseeing the service
- spoke with 11 patients
- spoke with the relatives of 10 patients
- reviewed CCTV footage of seven incidents
- reviewed other documents concerning the operation of the service.

Summary of this inspection

Areas for improvement

- The provider must review and approve a new staffing matrix for all four wards, to ensure there are sufficient staff working to safely meet the needs of the patients on those wards. Regulation 18(1)
- The provider must ensure that a sufficient number of registered nurses, and support workers, are directly employed, to improve the quality and safety of care provided to patients. Regulation 12(2)(a)
- The provider must ensure that all registered nurses and support workers at Cygnet Hospital Beckton have undertaken Prevention and Management of Violence and Aggression training, or if appropriate, refresher training, within the previous year, including bank and agency staff. Regulation 13(4)(b)
- The provider must ensure that all staff, including all bank and agency nursing staff working on short and long-term contracts, attend a workshop facilitated by the Cygnet Freedom to Speak Up Guardian so they feel confident to speak out where needed and report serious incidents without fear of retribution. Regulation 13(1)(2)(4)(b)
- The provider must ensure that a CCTV system, with coverage of all four wards and other treatment and clinical areas, is installed and operational, with the capacity to record and store images for at least 28 days. Regulation 13(1)(2)
- The provider must ensure that suitably qualified and competent senior staff review all available CCTV images of all incidents and write a report on every incident where CCTV images appear to show staff using unauthorised breakaway or restraint techniques, or otherwise incidents which appear to show any safeguarding concerns. These reports must be sent to the CQC. Regulation 13(1)(2)
- The provider must provide all nursing staff, including all bank and agency staff working on short and long-term contracts, appropriate, and ideally face to face, skills-based training specific to the patient group on the ward in which they work. Regulation 18(2)(a)
- The provider must have plans in place to provide all clinical practice leads, ward managers and service managers appropriate leadership development training. Regulation 18(2)(a)
- The provider must ensure patients' relatives or carers are fully involved in patients' care and treatment. Regulation 9(3)(c)(d)(g)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inadequate	Not inspected	Inadequate	Not inspected	Inadequate	Inadequate
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Not inspected	Requires Improvement	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Inadequate	Not inspected	Inadequate	Inadequate

Inadequate

Wards for people with learning disabilities or autism

Safe	Inadequate
Caring	Inadequate
Well-led	Inadequate

Are Wards for people with learning disabilities or autism safe?

Inadequate

We rated the service as Inadequate because:

- An incident on CCTV showed a staff member behaving in an intimidating way. On separate occasions, two staff members pushed the patient backwards when there appeared to be no justification for doing so. We identified a further incident on CCTV when staff, briefly, pulled a patient up from the floor by the patient's wrist. This was not an authorised restraint technique and increased the risk of serious harm to the patient.
- There had been an incident where a patient had been aggressive and had been locked out in the ward garden for at least 20 minutes. At the time, the weather was very cold. There was no CCTV evidence of this incident, as the CCTV system was outdated and did not consistently store footage.
- Nursing staff had not raised the incidents of staff appearing to abuse patients, or using unauthorised restraint techniques, with any managers. Managers became aware of these incidents following complaints about staff or when investigating other matters.
- The vacancy rate for support workers was 50%. However, the number of support worker posts had recently been significantly increased to provide more consistent care for patients requiring continuous observation by staff.
- Four nursing staff were rostered to work at night. This included where a staff member was required to continuously observe a patient. With staff members also requiring a break, this often left two nursing staff available to meet patients' needs and deal with emergencies. If a patient was aggressive or assaulting another patient or staff, there were not enough staff immediately available on the ward to safely restrain the patient, if necessary.
- Between November 2020 and January 2021 there were fifteen shifts when there were fewer nursing staff than the agreed minimum staffing level. Three of these shifts were night shifts. Staffing levels had been affected by staff being off sick or shielding due to COVID-19. The advocate for the hospital had recently had feedback from patients that the ward did not have enough staff.
- The hospital manager had started a system for managers to randomly review CCTV footage for one or two incidents per week on each ward. These were not always carried out as planned. However, reviews of CCTV footage for specific incidents which caused concern were undertaken by the management team.

However:

- The ward had one vacancy for a registered nurse. Five of the seven nurses on the ward were registered learning disability nurses. This included two team leaders. Two more registered learning disability nurses had been recruited and were awaiting recruitment checks.
- There had been a relaunch of the least restrictive practice programme to ensure patients did not have unnecessary restrictions placed upon them.

Inadequate

Wards for people with learning disabilities or autism

Are Wards for people with learning disabilities or autism caring?

Inadequate

We rated the service as Inadequate because:

- Two of the six patients we spoke with told us that some staff were rude and unhelpful. The advocate had also recently heard from patients that staff could be rude.
- Three of the six patients' relatives we spoke with said staff did not involve them in patients care. Two relatives said that staff did not contact or speak with them.
- The advocate had recently heard from patients that their care plans said male staff should only restrain them as a last resort. The advocate heard that this did not happen in practice.

However:

- We observed staff speaking and behaving appropriately with patients on the ward.
- Three patients' relatives said that staff were nice, answered questions, and involved them in patients' care. Two of them received weekly updates from staff.
- Three patients said that staff were good and they cared, and another said they just needed more training.

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

Inadequate

We rated the service as Inadequate because:

- Managers had not created a culture where staff were able to consistently raise concerns about unacceptable staff conduct or behaviour.
- Further work was required to ensure all patients' relatives were fully involved with patients' care and treatment.
- There were plans to review the number of nursing staff on each shift. However, this plan would result in there still being an insufficient number of staff at night to keep patients safe.
- The hospital manager had proposed leadership training for ward managers and team leaders since November 2019. The hospital manager had not been supported by senior managers to put these learning and development opportunities into place in a timely way.

However:

- The hospital manager had identified gaps in the care provided to patients. Regular night visits by hospital managers had been introduced.
- The hospital management team informed the local safeguarding team, CQC and the police, following incidents of alleged abuse.

Acute wards for adults of working age and psychiatric intensive care units

Inadequate

Safe	Inadequate
Caring	Requires Improvement
Well-led	Inadequate

Are Acute wards for adults of working age and psychiatric intensive care units safe?

Inadequate

We rated the service as Inadequate because:

- CCTV footage showed an incident at night when a patient was, without justification, restrained by staff. The patient was restrained using unauthorised restraint techniques and taken to a de-escalation room. The patient was then locked in the room without being observed by staff and tied a ligature. The patient was in seclusion, without the monitoring and recording required by the Mental Health Act Code of Practice (2015). The patient was placed at increased risk of harm.
- The use of unauthorised restraint techniques and seclusion without safeguards was not reported by nursing staff to managers. The incident came to the attention of managers following a patient complaint.
- When the ward had up to ten patients, four staff were rostered to work at night. This included where a staff member was required to continuously observe a patient. With staff members also requiring a break, this often left two nursing staff available to meet patients' needs and deal with emergencies. If a patient was aggressive or assaulting another patient or staff, there were not enough staff immediately available on the ward to safely restrain the patient if necessary.
- Between November 2020 and January 2021 there were nineteen shifts when there were fewer nursing staff than the agreed minimum staffing level. Six of these shifts were night shifts. Staffing levels had been affected by staff being off sick or shielding due to COVID-19. The independent mental health advocate for the hospital had recently been told by patients that the ward did not have enough staff.
- The vacancy rate for registered nurse posts was 66%. This included two of the three clinical practice lead (deputy manager) posts. The vacancy rate for support workers was 50%. However, the hospital manager had calculated the historical use of additional staff to carry out the continuous observation of patients. Rather than using agency or bank staff for these observations, the hospital manager had created more support worker posts to improve consistency of care. An additional 16 posts had been created for the ward.
- The hospital manager had started a system for managers to randomly review CCTV footage of one or two incidents per week on each ward. These were not always carried out as planned. However, reviews of CCTV footage for specific incidents which caused concern were undertaken by the management team.

However:

- Three agency staff were working on short-term contracts. This meant that there was consistency in care and these staff knew the patients.
- There had been a relaunch of the least restrictive practice programme to ensure patients did not have unnecessary restrictions placed upon them.

Are Acute wards for adults of working age and psychiatric intensive care units caring?

Acute wards for adults of working age and psychiatric intensive care units

Inadequate

Requires Improvement

We rated the service as Requires Improvement because:

- The advocate told us that patients' had recently said that they felt neglected and ignored by staff.
- CCTV of an incident showed a patient seeking staff assistance. A staff member spoke with the patient from the other side of the sealed office window. This then led to an incident when staff restrained the patient when there was no justification for doing so.

However:

- We observed that staff spoke with patients with respect. Staff responded to patients' frustration, anger and agitation in a calm manner, providing explanations.
- Three of the four patients we spoke with said that staff were kind and treated them well.
- Two of the three patients' relatives we spoke with described staff as answering questions and involving them in patients' care. However, two relatives said they did not always get accurate information from staff. Two relatives received weekly updates from staff.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Inadequate

We rated the service as Inadequate because:

- A recruitment and retention strategy for registered nurses had recently been introduced. However, the high number of registered nurse vacancies meant that it had made little progress and there had been limited impact.
- Managers had not created a culture where staff were able to consistently raise concerns about unacceptable staff conduct or behaviour.
- There was poor and inconsistent nursing leadership. The hospital manager had identified that improvement in ward leadership was needed. The ward manager had recently left after less than six months in post. A ward manager from another ward in the hospital had recently taken up the post temporarily. Poor nursing leadership and registered nurse vacancies contributed to inconsistent standards of care and a poor culture.
- There were plans to review the number of nursing staff on each shift. However, this plan would result in there still being an insufficient number of staff at night to keep patients safe.
- The number of registered nurse vacancies in the hospital had been on the hospital risk register since November 2018. The hospital manager had repeatedly escalated this to the provider's senior managers with possible solutions. These included improved staff facilities and benchmarking registered nurse pay with other local services. However, no effective action had been taken to improve the situation in a timely way.
- The hospital manager had proposed leadership training for ward managers and team leaders since November 2019. The hospital manager had not been supported by senior managers to put these learning and development opportunities into place in a timely way.

However:

Acute wards for adults of working age and psychiatric intensive care units

Inadequate

- The hospital manager had identified gaps in the care provided to patients. Regular night visits by hospital managers had been introduced.
- The hospital manager had introduced agency staff on short term contracts as a temporary solution to the high number of nursing vacancies on the ward. These staff worked regular shifts and could provided consistency in care to patients.
- The hospital management team informed the local safeguarding team, CQC and the police, following incidents of alleged abuse.

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
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not always enable and support relatives to understand the care and treatment choices available to the service user, to participate in making decisions relating to the service users' care and treatment, or provide them with information they would reasonably need.** **Regulation 9(3)(c)(d)(g)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure that a sufficient number of registered nurses, and support workers, were directly employed, to improve the quality and safety of care provided to patients.** **Regulation 12(2)(a)**

This section is primarily information for the provider

Enforcement actions

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	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed to meet the needs of service users.** **Persons employed by the provider did not receive appropriate training to enable them to carry out the duties they were employed to perform.** Regulation 18(1)(2)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider had not ensured service users were protected from abuse or improper treatment. Systems and processes were not operated effectively to prevent abuse of service users.** **Care of service users was provided in a way that included acts intended to control or restrain service users that were not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual.** Regulation 13(1)(2)(4)(b)