Cypress

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

We carried out this unannounced inspection in response to a serious incident at the hospital. We focused on specific aspects of two key questions, '**safe'** and '**effective.** This was to establish whether the provider had adequate safeguards in place to keep patients safe and to review the measures the provider had put in place to mitigate the potential risks.

- The building was not purpose built and there were multiple ligature points. Risk of ligature was reduced through the assessment of patients. Patients who were a known suicide risk were not admitted. All patients were risk assessed, such as for risk of self harm and ligature history.
- The service carried out regular ligature audits and staff mitigated ligature and other risks through observations and engagement. Staff followed the observation and engagement policies and followed procedures and recorded observations of all patients. Policies on risk and observation were embedded in the team.
- The provider planned to move from the current premises to a purpose built unit that was designed to minimise ligature risk. Notice had been given on the lease of the current building and they were expecting to move in January 2018.
- The provider had responded to the shortage of two trained nurses and had closed two beds to ensure safe staffing levels in the short term. The provider was actively recruiting for trained staff.
- Staff were debriefed after incidents and learning was shared across the team. Staff knew how to report incidents and the culture was open and transparent in response to incidents, with evidence of improvement in practice.
- Patients and staff were positive about the service and patients told us that they felt safe and staff told us that they felt supported.
- The provider worked well with partners, such as the local mental health trust. Cypress staff attended regular meetings with the wards and crisis staff. The crisis team were on site at Cypress three days a week and worked in close partnership with the provider. Information was shared between the local trust and Cypress, with read only care plan information for senior staff. The provider was in the process of implementing a joint action plan with Devon Partnership NHS Trust to improve access to care records so that there was access for all staff.

However;

- The regular ligature audits had not addressed all the environmental risks, we asked the provider to revisit this with Devon Partnership NHS Trust and carry out a joint ligature audit.

Summary of findings

- Although individual risk was discussed in handover meetings and regular meetings with the crisis team and ward, the provider admission documentation did not always specifically include a prompt to exclude any patients with a current or historical ligature risk.
- Staff felt well supported and supervised, but the provider was not meeting its appraisal targets.

Summary of findings

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Services we looked at
Acute wards for adults of working age and psychiatric intensive care units.

Summary of this inspection

Our inspection team

The team that inspected this service comprised two CQC Inspectors; Sarah Lyle, lead inspector and another CQC Inspector.

Why we carried out this inspection

We carried out a focused inspection in response to concerns raised following a serious incident at the hospital. This was an unannounced inspection.

When we last inspected the location in January2016, we rated Cypress as **requires improvement** overall.

We rated the core service as **requires improvement** for 'safe' and 'effective' and **good** for 'responsive', 'caring' and 'well-led'.

We did not follow up these judgements during this inspection and did not review the current ratings.

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?

Before the inspection, we reviewed information that we held about the location including information from stakeholders.

During the inspection visit, the inspection team:

- Visited Cypress and looked at the quality of the environment for patients.
- Interviewed the deputy manager.
- Spoke with the two unit psychiatrists.
- Spoke with two qualified nurse and three support workers.
- Spoke with the occupational therapist.
- Observed a handover meeting.
- Looked at six staff records.
- Interviewed the clinical governance lead for the provider.
- Spoke with two patients.
- Looked at five care and treatment records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Looked at two MHA records.
- Looked at all medication records.

Information about Cypress

Cypress is an independent mental health hospital situated in a converted house in Paignton. The provider is due to move to a purpose built unit in January 2018.

Cypress is part of the acute care pathway for Torbay and South Devon and provides a service for people who are usually resident in that area.

Summary of this inspection

The service provides “step-down” and short-term crisis admissions for up to 12 men and women over the age of 18 years. Step-down rehabilitation is for people who are currently in an acute hospital setting who no longer need the support of an acute ward. However, they may still require hospital support for short periods of time. Crisis placements are for patients who need a short-term level of hospital support but do not need the facilities of an acute ward. At this service the majority of patients did not stay beyond the maximum of 28 days.

The service is managed by Community Care Trust (South West) Limited, trading as Step One Charity, which is a registered charity that provides a range of services for people with mental health problems in Torbay and South Devon.

There were ten patients at the hospital during our inspection, following a planned discharge of one patient during that morning.

Cypress is registered to carry out:

- Accommodation for persons who require nursing or personal care.
- Treatment of disease, disorder or injury.
- Assessment or medical treatment for persons detained under the 1983 Mental Health Act.

There is a registered manager in place and a nominated individual.

What people who use the service say

We spoke with two patients who both expressed their satisfaction about the provider. Patients told us that they felt safe and described staff as helpful and supportive. They told us that all the staff were good and easy to talk to.

Neither patient was sure about whether they had been offered copies of their care plans but both knew about their care, such as their discharge plans. They confirmed that staff supported them to go out and enjoyed groups, activities and coffee mornings.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not re-rate this key question during this inspection. This key question is currently rated as requires improvement.

- Staffing levels had been risk assessed to ensure safe staffing and skill mix. In response the provider had temporarily closed two beds while the provider recruited to a qualified nurse post and long term cover of another qualified nurse position.
- The provider had a stable workforce team, including the manager and deputy manager and turnover was low.
- Policies on risk and observation were embedded in the team.
- Hourly observation of all patients took place.
- Risk assessments were reviewed and updated regularly in care plans, during handovers and other meetings.
- Staff were debriefed following incidents and information was shared across the team.
- Staff were aware of and involved in changes and improvements in practice as a result of incidents.

However;

- Although the provider was shortly moving to a purpose built environment that was designed to minimise ligature risk, the current ligature points were not fully mitigated. For example, some actions had not been followed up on from the ligature audit, such as radiator covers that were loose and roller blinds with long cords.
- Staff were not able to easily observe all parts of the ward and mirrors were not used to improve observation of blind spots.
- Although the provider did not accept admissions of patients assessed as high risk of suicide or self harm, which was well understood, risk documentation did not specifically include ligature risk and ligature history.

Are services effective?

We did not re-rate this key question during this inspection. This key question is currently rated as requires improvement.

- Care plans were holistic and recovery focused with evidence of regular physical health checks.
- The range of mental health staff included nurses, consultants, occupational therapy and access to psychology.

Summary of this inspection

- The provider worked well with its partners to provide specialist step down and crisis care.
- Good multidisciplinary and inter agency work was in place, such as regular meetings with the acute ward staff, crisis team and pharmacy.
- Staff were supervised and felt well supported.
- The provider had introduced a recognised and validated assessment and outcome tool to measure recovery wellness recovery action plans (WRAP) in care records.

However;

- The provider used paper records and did not have full access to care record systems.
- Appraisal rates were below the providers' target of 90%.

Are services caring?

This key question was not inspected. This is currently rated as good.

Are services responsive?

This key question was not inspected. This is currently rated as good.

Are services well-led?

This key question was not inspected. This is currently rated as good.

Detailed findings from this inspection

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

Safe	
Effective	

Are acute wards for adults of working age and psychiatric instensive care unit services safe?

Safe and clean environment

- The environment was clean and homely.
- The building was not built for the purposes it was being used which created some challenges observing all parts of the ward. None of the bedroom doors had glass observation panels and there were no mirrors to improve observation of blind spots. Cypress was scheduled to move to a purpose built hospital in January 2018.
- Environmental risks were partly mitigated by staff completing hourly observations on all patients and high levels of engagement. Night-time observations were carried out by entering the patient's room. Patients we spoke complained that observations could be intrusive at night although understood the reasons for this.
- The observation policy had recently been updated and all staff were aware of the changes. Patients who required longer than 72 hours of level two support, which was observations every 15 minutes were transferred to an acute ward in the local mental health NHS trust.We reviewed records which demonstrated that a patient who recently needed a greater level of observations was transferred to an acute environment within 48 hours. Also the recording of observation had improved following a change to the observation policy; which meant that staff recorded patient observations in more detail and observations had increased at night.
- The provider undertook an annual ligature point audit using the Manchester ligature points audit tool. A ligature point is a place to which someone intent on self-harm might tie something to strangle themselves. Multiple ligature points had been identified and there was an action plan to reduce these. Work had been undertaken including replacing light fittings, installation of some anti-ligature curtains and boxing in exposed pipework. A weekly health and safety check was carried out. However, some actions had not been completed, such as replacing all curtains and blinds and light cords to meet anti ligature requirements. Some radiator covers were loose.
- The remaining potential ligature points were being partly mitigated by the staff's management of the ward. Ligature cutters were accessible to staff. The provider did not accept admissions of patients assessed as high risk of suicide. This was well understood by the admitting crisis team, consultants and ward team. The environment was not suitable for patient with a risk of using ligatures to self harm.
- There was access to alarms and nurse call systems with call bells throughout the house. All staff carried an alarm on a lanyard with a breakaway clasp.

Safe staffing

- The provider had a full time band 5 vacancy and were managing the long-term absence of full time band 5 nurse. The provider had conducted a recent safe staffing review and closed two beds on 28 June 2017 to maintain safe staffing levels. This had been agreed with commissioners and partners as a safe interim measure.
- The provider had a stable workforce with a low turnover. However, they had not been successful in recruiting to a trained nurse vacancy and long term cover of another trained nurse post. New ways of recruiting qualified staff had been identified, such as advertising for occupational therapy staff.
- The provider had set and agreed the numbers and grades of staff required to cover level one observation of all patients, which meant that patients were observed each hour. We checked records between April and June 2017 and saw that agreed observations levels had been carried out.
- Staffing levels were risk assessed and adjusted to meet the needs of the patients and we saw recent examples where an increase in staff had taken place.
- Records showed that agreed staffing levels were maintained. Regular bank and agency staff were used to cover sickness and absence.

- We did not see any examples of escorted leave or ward activities being cancelled due to lack of staff.
- There was medical cover in the day with a consultant for Teignbridge and a consultant for Torbay. Both had a set day where they carried out weekly multidisciplinary review meetings. The provider had access to call junior doctors based at the local adult mental health in patient unit. This cover was available during the day and out of hours.
- Staff received mandatory training and the compliance with mandatory training was 78%.

Assessing and managing risk to patients and staff

- Staff completed a risk assessment of all patients admitted to the ward. Risk assessments were completed and we found that risks were updated following incidents on the ward. We reviewed five sets of patient records on the day of the inspection and found that all risk assessments were completed and in date. However, there was not always a clear management plan that guided staff on how to work with patient risks. We reviewed care plans and there were identified risks that had not been covered when staff were planning care with patients. For example a patient at risk of self-neglect had not had a risk management or care plan put in place to assist recovery. A risk discussion took place for each patient in the weekly multidisciplinary team and individual risk assessments for each patient formed part of the multi-disciplinary team checklist.
- Staff used the observation policy to observe patients admitted to the hospital, this had been updated following a serious incident. We were told by staff that on the day of the inspection that everyone was on general hourly observations but that if there was a change in risk then observations would be changed accordingly. We reviewed patient's notes and found evidence that staff had responded to increased risk by increasing observation frequency from hourly to 15 minutes. Observation levels and risks were communicated with staff through the shift to shift handover. Staff felt that there had been an increase of more unwell patients being admitted to the unit so there was an increase in patients requiring more frequent observations. However, if patients were too unwell to be managed in the Cypress environment then staff transferred them to the local acute hospital. The updated observation policy had been communicated to staff as part of a dedicated team away day and in one to one supervision. This allowed staff to familiarise themselves with the new policy and discuss changes.
- The provider admission criteria was to only accept patients whose risks were lower than on an acute ward as the purpose of the ward was as a step-down from acute wards and crisis admissions that did not require acute hospital care.
- Beds were block booked for crisis and step down rehab patients in Teignbridge and Torbay area. The provider had a mix of crisis patient and step down rehabilitation and at the time of our inspection, eight patients were classified as requiring step down rehabilitation and two were crisis patients, assessed as not needing an acute hospital bed. From April 2016 to March 2017 one in four patients was classified as a crisis patient who did not require an acute ward. Three out of four were classified as needing step down rehabilitation.
- Informal patients were allowed to leave the hospital at will due to the open door policy. Staff stated that if there was an increase in risk with a patient then they would not lock the front door but respond to the individual. Blanket restrictions were only used when justified, for example hourly observations to mitigate the risk of self-harm, risks of the environment and to ensure high levels of engagement. For example, each patient was observed on a minimum of hourly observations which was a blanket requirement of the unit and to partly mitigate the risk of the environment.
- Staff were trained in level two safeguarding for adults and children and knew how to make a safeguarding alert. There was clear evidence in patient notes that safeguarding concerns were reported and followed up and joint working with the local authority. Staff communicated safeguarding updates through the handover process. There was information displayed around the ward office that guided staff on who to call in the event of a safeguarding concern.
- The provider did not seclude patients. Restraint was not used.
- There was good medicines management practice in place for transport, storage, dispensing, and medicines

reconciliation. A service level agreement was in place for medicines management which included support from a local pharmacist, a weekly pharmacist visit and audit of medicines.

Track record on safety

- There had been one serious incident in the last 12 months. An investigation and analysis had been undertaken in conjunction with Devon Partnership NHS Trust. In response to this the provider had implemented improvements such as a more robust observation policy. Support, counselling, training and debriefing had been implemented.

Reporting incidents and learning from when things go wrong

- All staff knew what to report and how to report. Staff received feedback on incidents they There was a policy for incident reporting and a separate policy for investigating serious incidents. The team recorded incidents on the provider's incident reporting form which was shared with the service manager and governance lead and reported to the commissioners. A process to share findings from incidents was in place through staff meetings and clinical governance meetings.
- Staff confirmed that they were debriefed and offered support after serious incidents. Records confirmed that staff were debriefed after incidents and a process was in place for all staff to be offered formal debriefing including counselling support and specialist staff helpline services.
- A monthly audit of incidents was presented to the monthly governance committee meetings to review trends and identify learning. The ward manager attended these meetings, which were intended to look for themes and identify action plans.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- Staff completed a comprehensive assessment of patient need on admission. This included an assessment of risk, physical health, capacity and consent. Admission paperwork was completed and helped inform care plans.
- For patients that had physical health problems there were care plans created to help them manage the problem.Staff showed evidence of continued physical health monitoring where needed, physical health problems were care planned accordingly with strategies in place to respond to deterioration in physical health.
- We reviewed five sets of notes to check on whether care plans had been completed. All sets of notes had care plans completed with clear evidence of discharge planning and recovery goals. All care plans were up to date. However, staff did not demonstrate that patients' views had been sought. It was not clear whether patients had been given their care plan but patients we spoke with stated that they were aware that they had a care plan.
- 'Read only' access to the NHS provider's records for patients had been arranged for the manager and deputy manager and this was in the process of being rolled out more widely.

Best practice in treatment and care

- The provider ran an in-house wellness recovery centre nearby that patients attended in addition to the activity at Cypress. Courses focused on understanding of mental health issues and support. For example, mindfulness, anger management, understanding self-harm, recovery action planning. This was managed by the occupational therapist at cypress and staff from Devon Recovery Learning College.
- The junior doctors from the local mental health trust carried out physical health checks and ongoing monitoring. There was good access to specialist care when needed, including attendance at outpatient clinics and inpatient treatment for physical healthcare if indicated. The manager gave examples of linking in with the dietitian and diabetic nurse and involving specialist staff in the care plans for patients with physical health and dietary needs, this was evidenced through the care planning process.

- The provider had introduced a recognised and validated assessment and outcome tool to measure recovery WRAP (wellness recovery action plans) in care records. The WRAP was a personalised wellness and recovery system.
- Staff participated in audit, for example, monthly clinical audit of patient records and medication records.

Skilled staff to deliver care

- There was a range of staff on the ward supporting patients and this included nurses and support staff. The provider had a full time occupational therapist. Doctors and social workers were not employed by the ward but were accessed via the local NHS trust and local authority.
- There was access to psychology on a case by case basis but this was not routinely available. The service had recruited a full time occupational therapist.
- Staff told us that they had access to reflective practice in order to reflect on and improve practice. For example, a recent away day included reflective practice.
- We reviewed six staff records. There were gaps in formal written supervision and some staff had not received two monthly supervision, as agreed by the provider in their policy. Staff we spoke with confirmed that they were supervised, appraised and felt well supported though formal and informal supervision, staff meetings and team briefings.
- An induction training plan was in place which all new staff had completed.
- The percentage of staff that had an appraisal in the last 12 months was 80% which was below the target of 90%.
- A recent staff survey had identified that staff wanted more specialist face to face training in addition to the mandatory and specialist on line training programme. Staff confirmed the provider had responded to this and further specialist training had been requested such as motivational interviewing and solution focused therapy for their role.
- We saw examples where poor staff performance had been addressed and the service had referred a staff member to the professional nursing and midwifery regulator.

Multi-disciplinary and inter-agency team work

- Handovers took place on each shift and included discussion around risk. This was recorded on a handover template with prompts about risk. We observed a handover meeting which demonstrated effective communication of patient progress, risks and observation levels. We found that the handover was comprehensive with professional discussion around each patient. Shift tasks such as escorted leave, observations and cooking were planned.
- Partnership working between the provider and Devon Partnership NHS Trust, consultants, ward team and crisis team were in place with clear lines of communication. Relationships were well established. Multidisciplinary meetings with the consultants took place for each area on a weekly basis. This was attended by the nursing team and crisis team and care coordinators and CMHT. Cypress staff attended twice weekly meetings with the wards and crisis staff to discuss any patients who might be ready for step down care. The crisis team were on site at Cypress three days a week and worked in close partnership with the provider.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should revisit the ligature audit and action plan and ensure that all possible action is taken to mitigate ligature risk for the remaining time that the service is running from the location address in Paignton.
- The provider should ensure that ligature risk, including historical risk is captured on referral and admission information particularly for crisis patients to ensure that patients who are risk are not admitted.
- The provider should ensure that it meets its own appraisal targets.