Cygnet Hospital Godden Green

Quality Report

Godden Green
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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	Requires improvement
Are services safe?	Requires improvement
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.

Summary of findings

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

Overall summary

Our rating of this service went down. We rated Cygnet Hospital Godden Green as requires improvement because:

- Following the last comprehensive inspection when the service was rated good, there was a subsequent focused inspection where the ratings did not change but there were several areas where the provider needed to make improvements. At this inspection we found the provider had made good progress with these improvements but there were some more to complete to ensure safe care.
- The hospital did not have a permanent registered manager and hospital director although interim arrangements had been put into place. Since the last comprehensive inspection standards of care and treatment had fluctuated and so a permanent manager was needed to deliver consistently high-quality care that could be sustained. In addition, the hospital was still under enhanced surveillance and was only treating six young people. Strong leadership combined with effective governance processes would be needed as this restriction on patient numbers was lifted and more young people were admitted to the hospital. After the inspection we were told that a permanent manager had been appointed but had not yet come into post.
- Robust systems were not fully embedded to enable staff to safely manage risks to young people. For example staff were not clear which young people could enter the clinic rooms when medication was being administered or where it was safer for this to take place elsewhere. Also, there was a lack of clarity from staff about which items should be removed from young people to avoid repeated self-harm.
- There were a few areas where medicines management needed to improve. There was medication in the resuscitation bag which was not listed on the audit. The hospital told us after the inspection that this was an error and has been removed. We saw inaccurate record keeping concerning medication management across the hospital's systems. For example, staff were expected to record information following rapid tranquilisation in multiple locations, leading to discrepancies between the recording information. The provider had not ensured that all the registered nursing staff had completed their medication competency assessment as per the hospital policy.
- There was no overall list of how many ligature cutters were on the ward. This meant that if a kit was used, there was no way of telling if any equipment had been left on the ward.
- There was no process in place to ensure that staff tested personal alarms and there was no record of alarms being signed out which could leave broken alarms in circulation.

However:

- The ward environments were safe and clean. The wards had enough nurses and doctors. Staff minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They followed good practice with respect to young people's competency and capacity to consent to or refuse treatment.

Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that could provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Summary of findings

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Summary of this inspection

Background to Cygnet Hospital Godden Green

Cygnet Hospital Godden Green provides acute inpatient child and adolescent mental health services. The Hospital also offers an onsite education centre, the Knole Development Centre. This is a Department of Education, Ofsted Registered, education centre.

The hospital previously also treated adults, but recently closed the adult wards. The hospital now only treats young people.

Cygnet Hospital Godden Green is registered to provide the following regulated activities:

- treatment of disease disorder or injury
- assessment or medical treatment for persons detained under the Mental Health Act 1983.

At the time of our inspection Cygnet Hospital Godden Green had an interim registered manager in place.

At the time of our inspection there was only one ward open, Knole ward, which was operating as a general adolescent unit. The other child and adolescent ward, Littleoaks ward, was closed. The service was under enhanced surveillance by the relevant stakeholders and had agreed to treat no more than six young people at one time due to concerns about the quality and safety of the service. At the time of our inspection there were five young people on the ward.

We last inspected this service in early January 2019. We carried out a focused inspection on Knole ward and Littleoaks ward, following concerns about the service being raised with us. These concerns included the leadership of the service, number and severity of incidents affecting the health, safety and welfare of young people on the wards, and the safety of the ward environment.

At the January 2019 inspection, we found breaches of regulations and told the provider they must improve their young people's and environmental risk assessments, ensure that young people have good access to therapeutic activity, ensure staff are not using restrictive practice to manage young people following incidents, ensure all staff are competent and skilled to deliver safe care and treatment especially, in the use of observations, restraint technique and de-escalation skills. We also told the provider that they must operate effective audit and governance systems and processes to monitor and improve the service, analyse themes and trends of incidents and review the quality of staff's supervision. Finally, we told the provider that they must ensure that all notifiable incidents are reported to all relevant bodies. We told the provider they must comply with the requirements of the regulation by 31 March 2019. At the April 2019 inspection we found that the provider had made the necessary improvements.

Our inspection team

The team that inspected the service comprised two CQC inspectors, an assistant inspector, a nurse specialist advisor who specialised in child and adolescent mental health and a pharmacist specialist advisor.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

Summary of this inspection

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 visit, we reviewed information that we held about the location. We also attended quality review meetings at the hospital and reviewed the action plan from the previous inspection.

During the inspection visit, the inspection team:

- visited Knole ward, looked at the quality of the ward environment and observed how staff were caring for young people
- spoke with four young people who were using the service
- spoke with the registered manager and the ward manager
- spoke with nine other staff members including doctors, nurses, health care support workers, an occupational therapist, a psychologist and a clinical director
- spoke to two experts by experience
- spoke with an Independent Mental Health Advocate
- attended and observed the morning handover meeting, morning flash meeting and one multidisciplinary meeting
- looked at care and treatment records of five young people
- carried out a specific check of the medication management on the wards, including looking at five medication charts
- looked at a range of policies, procedures and other documents relating to the running of the service.

After the inspection we spoke with three carers/family members of young people in the service.

What people who use the service say

During the inspection we spoke with four young people who were receiving treatment at the service.

Some of the young people reported that the hospital had made improvements over the last few months. The young people commented the staff had improved because they were permanent and the young people found them more consistent. The young people were on the whole positive about staff, describing them as respectful and felt that the staff treated them with dignity. Some young people felt that some of the staff sometimes said the wrong thing to them when they were having a difficult time.

The young people told us that they felt safe on the ward. The majority of the young people we spoke with found the ward to be clean and well maintained.

The young people were pleased with the recent introduction of the allotment and small pets in the garden.

The majority of the young people commented that the food was satisfactory and that the kitchen catered for any dietary requirements. They also told us that they enjoyed eating their meals in the main dining room, off the ward, with the staff.

The young people felt that the activities during the week had improved and there was a lot to do, but that the evenings and weekends still could be a bit quiet and lacked activities.

Some of the young people felt that they would benefit from having more psychology sessions per week and would like to see their doctor more often.

Young people told us that their physical health was well managed.

All the young people that we spoke with were aware that they were able to access an Independent Mental Health Advocate (IMHA) and had a good relationship with the IMHA who visited the ward on a weekly basis.

Summary of this inspection

The young people told us that they were able to give feedback about the service at the weekly community meeting and were able to speak to the hospital director.

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?

Requires improvement 

Our rating of this service went down. We rated safe as requires improvement because:

- Robust systems were not fully embedded to enable staff to safely manage risks to young people. For example, staff were not clear which young people could enter the clinic rooms when medication was being administered or where it was safer for this to take place elsewhere. Also, there was a lack of clarity from staff about which items should be removed from young people to avoid repeated self-harm.
- There were a few areas where medicines management needed to improve. There was medication in the resuscitation bag which was not listed on the audit. This would mean there was no way of ensuring these were replaced after use or if the medication had been removed. We saw inaccurate record keeping concerning medication management across the hospital's systems. For example, staff were expected to record information following rapid tranquilisation in multiple locations, leading to discrepancies between the recording information. The provider had not ensured that all the registered nursing staff had completed their medication competency assessment as per the hospital policy.
- There was no process in place to ensure that staff tested personal alarms and there was no record of alarms being signed out which could leave broken alarms in circulation.

However:

- The service had made all the improvements requested from our last inspection.
- The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose. The service had enough nursing and medical staff.
- Staff regularly reviewed the effects of medications on each patient's physical health.
- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Summary of this inspection

- Staff understood how to protect young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.When things went wrong, staff apologised and gave young people honest information and suitable support.

Are services effective?

Good

We rated effective as good because:

- The service had made all the improvements, requested from our last inspection.
- Staff assessed the physical and mental health of all young people on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that young people had good access to physical healthcare and supported young people to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward team included or had access to the full range of specialists required to meet the needs of young people on the ward. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit young people. They supported each other to make sure young people had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Summary of this inspection

- 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 young people's rights to them.
- Staff supported young people to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17, and the principles of Gillick competence as they applied to young people under 16. Staff assessed and recorded consent and capacity or competence clearly for young people who might have impaired mental capacity or competence.

Are services caring?

Good

We rated caring as good because:

- Staff treated young people with compassion and kindness. They respected young people's privacy and dignity. They understood the individual needs of young people and supported young people to understand and manage their care, treatment or condition.
- Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that young people had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Good

We rated responsive as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway.
- The design, layout, and furnishings of the ward/service supported young people's treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- Staff facilitated young people's access to high quality education throughout their time on the ward.
- The food was of a good quality and young people could make hot drinks and snacks at any time.
- The wards met the needs of all young people who used the service – including those with a protected characteristic. Staff helped young people with communication, advocacy and cultural and spiritual support.

Summary of this inspection

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Requires improvement

Our rating of this service went down. We rated well-led as requires improvement because:

- The hospital did not have a permanent registered manager and hospital director although interim arrangements had been put into place. Since the last comprehensive inspection standards of care and treatment had fluctuated and so a permanent manager was needed to deliver consistently high-quality care that could be sustained. In addition, the hospital was still under enhanced surveillance and was only treating six young people. Strong leadership combined with effective governance processes would be needed as this restriction on patient numbers was lifted and more young people were admitted to the hospital. After the inspection we were told that a permanent manager had been appointed but had not yet come into post.
- The governance processes in the hospital had not managed to identify that some of the measured needed to ensure safety for the patients were adequately in place.

However:

- Under the recent new leadership staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

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.

All staff had received training in the Mental Health Act.

At the time of our inspection three of the young people were detained under the Mental Health Act.

Staff explained to young people their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Where necessary young people's treatment was authorised under the Mental Health Act.

The young people had access to information about independent mental health advocacy and an independent mental health advocate visited the ward once a week and attended the young people's ward rounds. Young people that we spoke with were complimentary about their relationship with the advocate.

Staff ensured that young people were able to take section 17 leave (permission for patient to leave hospital) when this had been granted.

Staff at the service had access to a Mental Health Act administrator for support and advice when needed.

The Mental Health Act Administrator carried out a Mental Health Act audit each month.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had received training in the Mental Capacity Act.

Staff had a good understanding of the Mental Capacity Act. The Act providers a legal framework for people to use when someone lacks capacity to make a decision and provides guidance for decision making where people are unable to make decisions themselves. Staff understood the reasons for assessing Gillick competence. (A test in medical law to decide whether a child under 16 years old is competent to consent to medical examination or treatment without the need for parental permission or knowledge.)

Young people's records showed that each of them had had an assessment of their capacity or competence to consent to treatment

The doctor took a lead in assessing and completing capacity and Gillick competence assessments. Staff told us that the doctors were responsive if the nursing team had cause for concern or an assessment was needed. Staff were able to give specific appropriate examples of when a capacity assessment was requested and carried out by the doctor.

The service had a policy on the Mental Capacity Act, which staff were aware of.

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Requires improvement

Safe and clean environment

- The ward layout did not allow staff to observe all parts of the ward but this had been mitigated by refractive mirrors and closed-circuit television. Staff had fobs to enter the ward through an airlock to reception.
- Staff carried out regular environmental risk assessments.
- A ligature audit was carried out and up to date, staff had mitigated and recorded the risks adequately for any ligature points. A ligature anchor point is a fixed point from which someone could tie things in order to self-harm. The ward stocked ligature-cutting kits.
- The ward was a mixed-sex ward, all the rooms were single occupancy and had their own en-suite bathroom. This complied with the national guidance on same sex accommodation. Female patients had access to a female-only lounge.
- Staff had easy access to alarms and carried personal alarms. However, staff we spoke to reported that there had been occasions where their alarms had failed to activate when needed. We viewed an incident report where a patient gained access to the clinic room and took medication and sharps. During this incident, when the staff member pulled their personal alarm, it failed to sound. We were told that it was the responsibility of the security staff to check the alarms, not individual staff members. On the day of the incident the alarm had not been signed out in the recording book.
- The environment was clean and had good furnishings which were well maintained. Daily updated information about activities and psychology was displayed on colourful blackboards on the ward for young people.
- Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. The hospital had daily and weekly cleaning rotas, as well as a monthly deep-clean rota.
- There was an extra-care room on the ward, which consisted of a room with a large sofa. The ward used this room as a quiet room for young people or as a de-escalation area. There was also a decommissioned seclusion room which was locked at all times and staff reported that they did not have keys to access it. The hospital director told us that there were plans to redevelop this room for another use.
- The clinic room was clean and tidy. However, there was not a general cleaning schedule for the area and the service. We noted one occasion where medication could not be given as it was out of stock.
- The ward was equipped with accessible resuscitation equipment. The clinic room contained emergency medication, such as EpiPen's but did not stock emergency medication for the reversal of benzodiazepines. An EpiPen is a medication used in an emergency to treat very serious allergic reactions. Benzodiazepines are a group of medications which act as a sedative. We were told that this was because, as per

the provider's policy, the staff were not trained to manage the medication.The visiting pharmacist checked emergency medication weekly for expiry dates that needed replacing.

- We found two vials of adrenaline in the resuscitation bag which was kept in the nursing office. These were not listed on the resuscitation bag audit sheet. After the inspection, the hospital told us that these were placed in the bag in error and had now been removed.
- We found that young people had access to the clinic room when medication was being dispensed. Staff told us that access was based on individual risk assessment of the young people but was not recorded.
- Staff had allocated roles on the ward each day, such as security.

Safe staffing

- The hospital had a two-shift pattern with shifts operating 7.30am to 8pm and 7.30pm to 8am. The service operated with six staff on each shift, two registered nurses and four health care support workers. However, recently the ward has been operating with two additional health care support workers on each shift to ensure that the young people could access the community on leave.
- The service employed 11 registered nurses, of which eight were permanent staff and three were contracted agency staff. The service employed over 30 health care support workers. The ward was fully staffed.
- The service was in the process of recruiting a physical health nurse.
- Staffing levels allowed young people to have regular one-to-one time with their named nurse. However, young people commented that they were only able to have one-to-one meetings with their named nurse when they were working and sometimes found it hard to approach other staff if they were having a difficult day. The ward had sufficient staffing, in the last three months young people's leave was never cancelled due to staffing issues.
- Staff felt that there were sufficient staff to carry out physical interventions if needed. The ward had 37 incidents of restraint involving 10 separate young people in December 2018, 40 incidents of restraint involving 9 young people in January 2019 and 13 incidents of restraint involving 4 young people in February 2019.
- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. The service employed two consultants, one of whom was the medical director, and one specialty doctor. On-call doctors were employed to provide medical care at night.
- The service employed psychologists, psychology assistants, occupational therapists, and occupational therapy assistants.
- A staffing matrix was in placed which stated the minimum number of qualified and unqualified staff needed on the wards. We observed adequate staffing levels on the ward.
- Staff had received and were up to date with appropriate mandatory training. Training courses included PMVA (training to manage violence and aggression), infection control, basic life support, equality and diversity, health and safety, responding to emergencies, safeguarding, Mental Health Act awareness, introduction to monitoring physical health, Mental Capacity Act and Deprivation of Liberty Safeguards, physical health, dealing with concerns at work, food safety, immediate life support, information governance, safeguarding, online safety marshal and suicide and risk training.
- A dedicated staff member monitored compliance with training and emailed the ward manager with reminders for staff that needed training.

Assessing and managing risk to young people and staff

- We viewed all five young people's care records during the inspection.
- Staff did a risk assessment of every young person on admission and updated it regularly, including after any incident. We saw evidence that staff identified and responded to changing risks. However, in some care records we did not see the rationale for some decisions around risk documented. For example, staff failed to document why they did not remove an item from a young person who tried used it to self-harm. The young person then went on to self-harm with the object again.

Requires improvement

Child and adolescent mental health wards

- At our last inspection we had concerns with staff recording of observations of young people. The service had addressed this issue with further training for staff. During this inspection staff followed good policies and procedures for use of observation and we saw that observation charts were recorded at the time and were up to date. At our last inspection we observed inappropriate techniques used during restraint, since our last inspection the provider addressed these concerns with additional training for staff.
- The service had reviewed its blanket restrictions since our last inspection and had recently allowed the young people to have their mobile phones on the ward, subject to individual risk assessments. Additionally, the young people had been allowed board games and a games console, which was previously a blanket ban.
- Staff adhered to best practice in implementing a smoke-free policy. Young people that did smoke were provided with cessation support and nicotine replacement therapy.
- Young people who were on the ward as informal patients could leave at will and knew this was the case. A clear sign was displayed on the outside of the nurses' station and young people we spoke to, who were informal, were aware of their right to leave.
- Since our last inspection in January 2019 there had been no episodes of seclusion or long-term segregation. Seclusion or segregation are where staff prevent a person from leaving a designated room or rooms. The ward had a decommissioned seclusion room. The hospital director told us there were plans to refurbish the room for another use.
- Staff used restraint only after de-escalation had failed. We heard staff discuss techniques in the morning handover meeting. Staff also told us that they tried to de-escalate the young people, using tools such as their positive behaviour support plans, rather than use restrictive interventions, such as physical restraint.
- Since our last inspection in January 2019 rapid tranquilisation (rapid tranquilisation is the use of medication, usually intramuscular if oral medication is not possible or appropriate, and urgent sedation with medication is required) had been used 11 times in January and once in February. We found that staff were expected to record the physical observations following rapid tranquilisation in multiple locations. This led to discrepancies between the different records and we found one document failed to explain why observations following rapid tranquilisation had been discontinued or if the patient had refused.
- All young people were able to access their rooms all day. Young people did not have their own keys for their rooms.

Safeguarding

- All staff had completed their mandatory training in safeguarding and knew how to make a safeguarding alert. Staff told us that the relationship with the local authority safeguarding team had improved and their reporting had improved.
- At our inspection in January 2019 we found staff knew how to raise safeguarding concerns, but we found that the information sent to the local authority safeguarding team was not always accurate or reflective of the event. The provider had addressed this issue with a number of actions, including a safeguarding audit, a flow chart so it was clear how staff should respond to safeguarding concerns, and amendments to the policy. A new safeguarding lead had been appointed.
- Staff could give examples of recent safeguarding alerts and had a good understanding of safeguarding issues and their responsibilities in relation to identifying and reporting abuse. Staff were also confident to seek help from management if they had any concerns. Staff discussed how to help keep young people safe when using social media, through support, encouraged self-policing and intelligence received.
- Staff discussed safeguarding at a variety of forums, including morning handovers, flash meeting and weekly ward rounds. A hard copy of the safeguarding policy and procedure was easily available to staff.

Staff access to essential information

- Staff were expected to record information following incidents in more than one place. We saw some discrepancies in information that was recorded on the incident form for rapid tranquilisation and then on the paediatric early warning score (PEWS) file and the care records.

- All information needed to deliver patient care was available to all relevant staff, including agency staff, when they needed it and it was in an accessible form.

Medicines management

- We found issues with the medication management on the ward. We raised them with the service during our inspection. We saw a discrepancy between one young person's medication chart and the PEWS file on how often physical observations should be done per day. We also saw one young person had missed a dose of medication because it was not in stock.
- Medication were stored correctly and at the correct temperature.
- We looked at all young people's medication charts. We found on one that the dispensing nurse had indicated on the front of the mediation chart that the medication had not been given, but failed to record the reason on the back.
- We found that one young person's information on the medication chart and the electronic records did not match. The care records indicated that she was given medication, but it was not recorded on the medication chart.
- We found one patient had two medication charts, both with the same medication but each chart had different doses recorded. This meant that the patient could be accidentally given the medication twice. During the inspection we raised our concerns about this issue. The provider corrected the error and took appropriate action to ensure the individual no longer worked at the service whilst the incident was being investigated.
- We found that only four, out of six actively working registered mental health nurses had completed their medication competency assessment, in accordance with the hospital policy. One of the nurses had only completed the training following a medication error where a patient had been incorrectly given medication twice. Following the inspection, the hospital provided us with additional information about the staff who had not completed the training. There were 13 registered nurses, but only 6 were actively working at the hospital. Of the 13 staff, six staff were new starters and would complete the competency assessment as part of their induction and one was on maternity leave. Four had completed their competency assessment but only two had been added to the evidence file.
- A visiting pharmacist visited the ward on a weekly basis and checked the medication charts, fridge temperatures, clinical equipment, and answered any medication related issues. The pharmacist undertook weekly audits on medication to help improve practice and attending the monthly integrated governance meeting.

Track record on safety

- For the period of January to March 2019 the hospital reported 27 serious incidents.

Reporting incidents and learning from when things go wrong

- All staff knew what incidents needed reporting and staff told us that since the new management had been in place there had been a change in culture where staff felt supported, and able to raise incidents. Staff we spoke to felt that there had been a decrease in the number of incidents and in part attributed this to the use of permanent staff, rather than agency staff.
- At the January 2019 inspection we saw that the staff were unclear about which incidents needed to be reported to external agencies. For example, the staff had not completed all statutory notifications to the Care Quality Commission. Since the last inspection this had improved and this was no longer an issue.
- Staff we spoke to understood the Duty of Candour. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care service to notify clients (or relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff discussed incidents at a variety of forums, including the handovers and morning flash meetings, monthly ward training and integrated governance meetings. The service also shared learning from incidents with three other child and adolescent mental health wards also run by Cygnet.
- Staff and young people received a debrief and support after serious incidents.

Requires improvement

Child and adolescent mental health wards

- The service had made improvements to the safety for young people after learning from incidents. Young people had previously absconded from the front door of the hospital. It was now locked and controlled during the day by a receptionist and at night by staff using a key pad.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We viewed all five young people's care records. We found that all young people had a comprehensive assessment in a timely manner at, or soon after, admission. Staff used a formal risk screening tool.
- Staff carried out a range of assessments with young people on admission to the ward and throughout their care and treatment and these included physical health assessment. Physical health was also assessed each week at the ward round.
- Staff developed care plans that met the needs identified during assessments.
- At our last inspection we found that staff did not ensure that changes to young people's presentation or needs were captured in their care plan. During the inspection we did not find this was the case. We also saw evidence of the care plans being regularly reviewed.
- Care plans were personalised, holistic and recovery-orientated. Young people that we spoke with told us that they were involved in creating their care plans, and we clearly saw patient involvement throughout. Young people also told us that they were regularly provided with a copy of their care plan.
- Staff updated care plans when necessary, including after ward rounds.
- Young people had positive behaviour support plans developed. We observed that some young people had their positive behaviour support plans on the outside of their bedroom doors. Staff told us that young people had chosen to do this, found it helpful and had consented to this. We had concerns that when the number of young people on the ward increased this could leave young people's privacy compromised. After the inspection the hospital confirmed that the plans were displayed in the spirit of personalised care, with the young people letting their teams know what they wanted at times of difficulty and it was the young people's choice as to how they shared their information. There were also young people who had chosen not to display their plans on their doors. The hospital also confirmed that there was no personal or inappropriate information displayed on the plans.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE).
- At our last inspection we observed a lack of therapeutic activity and engagement between staff and the young people. At this inspection we saw that this had improved.
- Each young person had a personalised weekly timetable which included: education, psychology and a wide range of activities such as yoga, gym, cooking and baking, psychodrama, family therapy as well as trips to the community to do activities such as swimming and shopping. The timetables were updated once a month taking into consideration what activities the young people wanted to do. The service had recently put on a sports day for the young people. The hospital had recently installed a sensory garden, an allotment for the young people and rabbits and guinea pigs for the young people to care for.
- A timetable had also been created for the Easter break from education and included trips out to a local castle, sailing and a special Easter event. The service expected all young people to complete 25 hours of therapeutic activity per week. During the week of our inspection, the ward had achieved 80% of their target for therapeutic activity. They had newly admitted a patient who had not yet started their full activity programme. .
- The young people felt that there was enough to do during the week days and the right mix of activities. However, whilst there were activities on the schedules

for weekend and evening activities, the young people told us that they did not feel that there was always enough to do, which contributed to a rise in incidents in the evenings.

- The hospital told us that they felt it was important for there to be a balance for the young people on the weekends between activities, therapy and down time.
- The hospital was smoke free and young people who did smoke were offered smoking cessation support and nicotine replacement therapy.
- There were currently no young people receiving high dose anti-psychotic medication. Staff told us that if there were young people prescribed high dose antipsychotic, that this would be checked in the visiting pharmacist audits.
- Staff participated in clinical audit and quality improvement initiatives. Information from clinical audits was discussed at monthly integrated governance meetings. The ward manager told us that they received regular updates from the compliance team regarding national professional guidance or legislation and was able to cascade these to their team.
- The service had recently recruited the help of two experts by experience to help improve the service (experts by experience are people with lived experience of using services). We spoke with the two experts by experience who told us that they had seen improvement in the hospital and a positive change in the culture.

Skilled staff to deliver care

- The team included or had access to the full range of specialists required to meet the needs of the young people on the ward. The team consisted of doctors, nurses, health care support workers, occupational therapists, psychologists, a drama therapist, a family therapist, a social worker and a visiting pharmacist.
- The service had recently recruited new staff to the team who had started the hospital's new three-week induction period.
- At our last inspection we found problems with staff not receiving regular quality supervision. At this inspection we found staff were provided with regular supervision (supervision is a meeting to discuss case management, to reflect on and learn from practice, and for personal support and professional development). We saw that from January to April, all staff had received regular supervision. We also reviewed individual supervision records and found them to be personalised. Supervision records indicated that the following topics were discussed, workload, priorities appraisal objectives, performance, safeguarding, serious incidents, mandatory training, sickness/absence, welfare/ wellbeing.
- A team learning day was held for the ward staff. The ward had not had the learning day for February and March but had plans for it to be held in April. The monthly meeting included training and updates, as well as reviewing incidents and any learning from them.
- The majority of staff had had an appraisal in the last 12 months. For staff that had not had an appraisal, the service had a date booked in and a reason for why they had not had the appraisal.
- The visiting pharmacist told us that they did not attend individual young people's ward round meetings but were available to meet with young people individually at their request.
- Staff were able to attend monthly reflective practice sessions.

Multi-disciplinary and inter-agency team work

- Staff held a daily morning multidisciplinary meeting. A heads of department meeting and ward round were held every week.
- Staff had handovers between each shift. We observed a handover meeting during our inspection, which was attended by the full multidisciplinary team, including doctors, nurses and teachers. Staff effectively shared information about young people including risk levels, physical health, observation levels. We observed staff discussing de-escalation techniques that they had used with the young people. During the handover the team RAG-rated the ward (red, amber, green). However, we did not see staff referring to a scale or tool that they used to determine the risk level. After the inspection the hospital informed us that the multidisciplinary team rate the ward with a tool.

Requires improvement

Child and adolescent mental health wards

- We observed a ward round and saw each team member contributed. The discussion was effective and the young person's notes, care plans and risk were updated on the electronic recording system. Young people were encouraged to attend their ward rounds.
- We saw evidence of inter-agency working taking place with case managers attending weekly ward rounds.
- Staff and young people we spoke with told us they would have liked to see the health care support workers who were involved in the young people's day-to-day care more involved in decision making or multidisciplinary meetings.

Adherence to the MHA and the MHA Code of Practice

- All staff had received training in the Mental Health Act.
- At the time of our inspection three of the young people were detained under the Mental Health Act.
- Staff explained to young people their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.
- Where necessary young people's treatment was authorised under the Mental Health Act.
- Informal patients could leave at will and knew that. There was a clear sign in the window of the nurse's station and young people we spoke to, who were informal, understood their rights to leave.
- The young people had access to information about independent mental health advocacy and an independent mental health advocate visited the ward once a week and attended the young people's ward rounds. Young people that we spoke to were complimentary about their relationship with the advocate.
- Staff ensured that young people were able to take section 17 leave (permission for patient to leave hospital) when this had been granted.
- Staff at the service had access to a Mental Health Act administrator for support and advice when needed.
- The Mental Health Act administrator carried out a Mental Health Act audit each month.

Good practice in applying the Mental Capacity Act

- All staff had received training in the Mental Capacity Act.
- Staff had a good understanding of the Mental Capacity Act. The Act provides a legal framework for people to use when someone lacks capacity to make a decision and provides guidance for decision making where people are unable to make decisions themselves. Staff understood the reasons for assessing Gillick competence. (A test in medical law to decide whether a child under 16 years old is competent to consent to medical examination or treatment without the need for parental permission or knowledge.)
- Young people's records showed that each of them had had an assessment of their capacity or competence to consent to treatment.
- The doctor took a lead in assessing and completing capacity and Gillick competence assessments. Staff told us that the doctors were responsive if the nursing team had cause for concern or an assessment was needed. Staff were able to give specific appropriate examples of when a capacity assessment was requested and carried out by the doctor.
- The service had a policy on the Mental Capacity Act, which staff were aware of.

Are child and adolescent mental health wards caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- Staff attitudes and behaviours when interacting with young people showed they were discreet, respectful, and responsive, providing young people with help and emotional support.
- The young people were overall positive about staff, describing them as respectful and felt that the staff treated them with dignity. Some young people felt that some of the staff sometimes said the wrong thing to them when they were having a challenging time.
- Staff understood the individual needs of young people, including their personal, cultural, social and religious needs.

Requires improvement

Child and adolescent mental health wards

- Family members of the young people that we spoke with told us they found the staff to be helpful and on the whole spoke positively about the interaction with them and the young people.

Involvement in care

- Young people were orientated to the ward on their admission and received a welcome pack. All young people had access to an independent mental health advocate, who visited the ward weekly.
- All young people had a named nurse and were able to speak to them.
- Staff involved young people in care planning and risk assessments. We saw evidence in all young people's care plans of their involvement. All young people were encouraged to attend their weekly ward round where their care plans and risk assessments were updated and discussed. Young people we spoke with told us that they were regularly provided with a copy of their care plan.
- The young people were involved in the recruitment of staff, including the interim hospital director.
- Young people were able to give feedback about the service at a weekly feedback meeting.
- Communication from staff with families and carers had significantly improved in the last few weeks. Family members of young people told us that the hospital called them most days to give them an update and that they had recently been given a dedicated contact name and details.
- Family members of young people that we spoke with commented on the improvements the hospital had made and that they had been given time with the interim registered manager to discuss their concerns.
- Family members had opportunity to give feedback at parents' forums, two had been held since January 2019.

Are child and adolescent mental health wards responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

- During our inspection, there was a limit on the number of young people that could be admitted to the ward due to concerns found with the service in the preceding months. The hospital had agreed with external agencies, including the CQC, to admit no more than six young people and this was being reviewed regularly. This figure had gone up from four young people just a week before our inspection. At the time of our inspection there were five young people on the ward.
- At the time of our inspection all admissions were planned. Staff told us that the admission process had recently changed and that the multidisciplinary teams' view on whether a new admission would be suitable was now taken into consideration, where it was not previously. Staff said that this meant they were able to refuse admissions if they felt it would unsettle the ward or that the admission was inappropriate for the service.
- Staff planned for young people's discharge, including good liaison with care managers/coordinators. At the time of our inspection there was one patient whose discharge was delayed, caused by a lack of availability in the young person's home area. All delayed discharges were flagged by the service and monitored by the service and NHS England.

The facilities promote recovery, comfort, dignity and confidentiality

- The young people had their own bedrooms, all with en-suite shower facilities and a toilet. The young people were able to personalise their bedrooms and had done so.
- The young people had somewhere secure to store their possessions. The ward manager told us that they had recently brought new storage crates for young people's possessions which were risk assessed and not permitted on the ward in order to keep them safe in storage.
- Staff and young had access to the full range of rooms and equipment to support treatment and care (clinical rooms to examine young people, activity and therapy rooms and access to a gymnasium and family room to meet visitors, off the ward).
- The young people had access to a large outside garden from the ward.

Requires improvement

Child and adolescent mental health wards

- Young people could make hot drinks and snacks on the ward at all times of the day and night. A choice of meals was available and freshly prepared in the hospital kitchen. Young people were encouraged to eat their meals in the dining room off the ward with the staff. Young people told us that any dietary requirements, such as veganism, were catered for.
- The young people were able to continue with their education when admitted and were able to attend the education centre which was staffed with full time teachers and Ofsted registered.
- The young people were involved in creating art work for the reception area and were involved in choosing new furniture and blankets for the ward.

Young people's engagement with the wider community

- Every young person had an occupational therapy assessment shortly after their admission to the ward. Subject to an individual risk assessment, young people went on group trips into the community to the shops, cinema, or cafes. The occupational therapy team could also offer individual therapy.
- Staff encouraged the young people to maintain contact with their families. Staff routinely invited family members to attend ward reviews and care programme approach meetings.

Meeting the needs of all people who use the service

- The ward was on the ground floor and was accessible for all. The education centre and gymnasium were accessed by the ward by stairs but there was also an alternative entrance at the back which was accessible without stairs.
- Managers ensured that staff and young people had easy access to interpreters where needed.
- The family room contained a range of religious text and aids, such as a prayer mat. Staff did their best to provide spiritual support such as visits from a local vicar, visits to local churches or mosques.

Listening to and learning from concerns and complaints

- Young people told us they knew how to complain. They were given information about how to complain in the welcome pack they received on admission. Young people were also encouraged and supported by staff to discuss concerns during the weekly community meetings.
- Staff told us that learning from complaints was shared across the ward, and hospital.
- Families and carers that we spoke with said that they would be confident reporting any concerns or complaints to the hospital. This was a recent change.

Are child and adolescent mental health wards well-led?

Requires improvement

Leadership

- Since the January 2019 inspection the provider had taken action to urgently improve the safety and quality of the service. At this inspection we found the ward manager had been in place for only a few weeks but had been acting as the manager for two months and employed by the hospital for two years. The service only had an interim registered manager in place, who had been brought in from another Cygnet hospital service to focus on improving the quality and standards in the service.
- Whilst we found that the senior managers and the registered manager had the skills and knowledge to perform their roles, we had concerns about the hospital's ability to maintain this improvement without the certainty of a permanent registered manager and hospital director. Many of the issues found at our most recent inspection in January 2019 had been similar concerns found on previous inspections.
- Staff, young people and families that we spoke with were positive about the recent changes in management and felt it had led to improvements in the service. However, given the early stage of the improvements, decreased patient numbers and lack of a permanent registered manager, we had reservations about the longevity of the improvements. We were not assured of the provider's ability to retain oversight of key aspects of safety and quality on an ongoing basis without enhanced multi-agency involvement and scrutiny.

- The hospital director and other senior staff were visible in the service and approachable for the young people, their families and staff.

Vision and strategy

- Staff knew and understood the provider's vision and valued and how they were applied in the work of their team.
- Staff had the opportunity to contribute to discussions about the strategy for their service, especially since the new leadership and since the service was changing.

Culture

- Staff we spoke to reported an improving culture at the hospital under the interim leadership. At our previous inspection staff described a culture that did not value staff or encourage staff to speak up when things were not going well. Staff on this inspection felt respected, supported and valued and felt able to raise concerns. Staff morale had significantly improved since the change in leadership and running of the hospital.
- Prior to the inspection in January 2019, we were receiving a higher than expected number of concerns raised by staff to the Care Quality Commission. These staff reported they were not supported to raise concerns by their managers and that managers did not listen or respond to their concerns. However, during this inspection staff reported they were able to raise any issues as they arose with their managers and that managers took their concerns seriously and acted where required.
- At the time of our inspection there were no grievance procedures or poor staff performance being dealt with.
- Staff appraisals included conversations about career development and how it could be supported.
- All the staff we spoke to were clearly passionate and proud to work at the hospital and displayed enthusiasm for their work and improving the service.
- The provider recognised staff success within the service. Staff and young people were encouraged to nominate staff members for an award each month.

Governance

- Whilst we saw improvements in the systems and procedures at Cygnet Hospital Godden Green, the hospital remained under enhanced surveillance by external bodies including the CQC. The service was limited to accepting only six young people at the time of this inspection. The service was putting in place effective governance systems but these processes were still bedding in. We were concerned that as the patient numbers increased, and the multiagency involvement and scrutiny reduced, the provider would not be able to sustain the improvements, as had been the case in the past.
- There was a clear framework of what must be discussed at a ward, team or senior management level in meetings to ensure that essential information was shared and discussed. The hospital held monthly integrated governance meetings which had a clear and comprehensive framework of what must be discussed at the meetings.
- Staff undertook local clinical audits and discussed the outcomes at the monthly integrated governance meetings. The audits were sufficient to provide assurance and staff acted on the results when needed.

Management of risk, issues and performance

- The service had a local risk register and overarching action plan. This was kept up to date by the managers and reviewed as part of their governance systems. There was also a corporate risk register.
- The hospital had recently recruited a large amount of new staff who all required training.
- We found at the last inspection that managers did not ensure that all staff were receiving regular and meaningful supervision. However, we found this time that all staff had received regular supervision.

Information management

- Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.
- Staff made notifications to external bodies as needed.

Engagement

- Staff had up-to-date information about the work of the provider and the service they used through an email news bulletin.

Requires improvement

Child and adolescent mental health wards

- Young people and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Young people and staff could meet with members of the provider's senior leadership team to give feedback.
- Senior leadership engaged with external stakeholders, such as commissioners, NHS England and safeguarding. The service currently held monthly quality improvement meetings as part of the enhanced monitoring.

Learning, continuous improvement and innovation

- Under the new management staff were given time and support to consider opportunities for improvement and innovation and this led to changes. Such as the ward manager introducing the boxes for storage.
- The service participated in the Quality network for inpatient child and adolescent service. (QNIC) peer review.
- The service had recently recruited the help of two experts by experience to help improve the service (experts by experience are people with first-hand experience of using services) to help improve the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- Systems were not fully embedded to allow staff to safely manage risks to young people for example access to the clinic rooms or access to things which young people could self-harm from.
- The provider must ensure the improvement of medicine management by taking action to ensure that all necessary staff complete the medication competency assessment and ensuring the accurate recording of medication management across all its systems and consider arrangements to ensure a system to ensure all medication in the resuscitation bag is recorded on the audit.
- The provider must consider arrangements to ensure that personal alarms are effectively tests and a record kept of alarms which are signed out to prevent broken alarms remaining in circulation.
- The provider must ensure the service is consistently managed by the appointment of a competent permanent registered manager. The provider must ensure systems and processes including leadership are established and operated to ensure effective compliance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose How the regulation was not being met: The provider failed to ensure there is accurate recording concerning medication management across all its systems. We saw a discrepancy between one young person's medication chart and the PEWS file on how often physical observations should be done per day. The provider did not have arrangements to ensure that personal alarms were effectively tests and a record kept of alarms which are signed out to prevent broken alarms remaining in circulation. We found that one young person's information on the medication chart and the electronic records did not match. The care records indicated that she was given medication, but it was not recorded on the medication chart. We found one patient had two medication charts, both with the same medication but each chart had different doses recorded. The provider had not ensured that all registered nurses had completed their medication competency assessment. Two out of the six registered nurses who were actively working had not completed their assessment.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 12(1)(g) the proper and safe management of medicines.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Health and Social Care Act (RA) Regulations 2014 How the regulation was not being met: The provider had not ensured that the service was consistently managed by the appointment of a competent permanent registered manager. Nor that the systems and processes including leadership were established and operating to ensure effective compliance. This was a breach of regulation 17(1)