

# Cygnets Hospital Harrow

## 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

As this was an unannounced, focused inspection of Byron Ward we did not rate this service following this inspection. During the inspection we focused on patient observation levels, physical restraint and how nursing staff cared for patients.

We undertook this inspection due to information of concern we had received about Byron Ward. This information described the frequent physical restraint of patients, without staff attempting to minimise this, all patients being subject to continuous observation by staff on admission, and staff behaviour being described as rude and unprofessional.

We found:

- Nursing staff did not always follow current infection control procedures and guidance concerning COVID-19.
- Two patients said that staff did not always knock on their bedroom doors before entering their bedrooms.
- Nursing staff had not received training in the safeguards model of conflict management, which had been introduced the previous year. This meant individual

staff members may have different levels of knowledge and understanding about safeguards. This could impact on the ability of staff to anticipate and manage patients' distress or conflict.

However:

- Staff dealt with patient conflict, aggression and distress by verbal de-escalation. There had been no recent incidents of the physical restraint of patients and restraint was used as a last resort.
- Staffing arrangements ensured consistency of care. Staffing vacancies were covered by long-term agency staff.
- Staff assessed potential risks to patients when they were first admitted. The ward had appropriate procedures for the management of risk when patients were first admitted to the ward. The level of staff observation of patients was based on individual patients' risk assessment.
- Staff treated patients with compassion and kindness. Patients were complimentary regarding nursing staff and how they were cared for.

# Summary of findings

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# Summary of this inspection

## Background to Cygnet Hospital Harrow

Cygnet Hospital Harrow has four wards:.

Byron ward – a 20 bed ward providing assessment, diagnosis and treatment for men and women with acute mental health needs.

Springs Unit – a 16 bed ward for men with autistic spectrum disorders who require a low secure environment.

Springs Wing – a 10 bed rehabilitation ward for men with autistic spectrum disorders.

Springs Centre – a 14 bed ward for men with a diagnosis of autism or mild learning

disability who also present with mental health needs.

Cygnet Hospital Harrow is registered to provide:

Assessment or medical treatment for persons detained under the Mental Health Act 1983;

Treatment of disease, disorder or injury

There was no registered manager in post at the time of the inspection. An application for a new registered manager had been submitted. Since the inspection this new registered manager application had been approved.

We have inspected Cygnet Hospital Harrow three times since 2015. At our last inspection in November 2018, we found the following breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 concerning Byron Ward:

Regulation 12 (Safe care and treatment) – Controlled drugs were not safely stored according to national guidance, there was no effective system to prevent overstocking of medicines, and there was a low completion rate for staff undertaking some types of mandatory training.

Regulation 15 (Premises and equipment) – Equipment used to monitor patients' physical health was not calibrated.

Regulation 18 (Staffing) – Some staff did not receive regular supervision.

At the November 2018 inspection, we rated the hospital as good overall. We rated the acute ward as requires improvement overall, along with requires improvement for being safe and effective. We rated caring, responsive and well-led as good. The forensic, rehabilitation and learning disabilities and autism wards were rated as good overall and for all key questions except safe, which was rated requires improvement.

## Our inspection team

Our inspection team consisted of three inspectors.

## Why we carried out this inspection

We undertook this inspection due to information of concern we had received about Byron Ward. This information described the frequent physical restraint of

patients, without staff attempting to minimise this, all patients being subject to continuous observation by staff on admission, and staff behaviour being described as rude and unprofessional.

# Summary of this inspection

## How we carried out this inspection

We undertook a weekend unannounced inspection visit to Byron Ward. Due to COVID-19 we interviewed the ward manager by teleconference.

As this was a focused inspection we only looked at specific areas concerning patient observation levels, physical restraint and how nursing staff cared for patients.

During the inspection visit, the inspection team:

- visited the ward and observed how staff were caring for patients;
- spoke with four patients who were using the service;
- spoke with two people who had been a patient on the ward in the last nine months
- spoke with the ward manager;
- spoke with six other staff members; including registered nurses and support workers
- looked at a range of documents relating to the running of the service

## What people who use the service say

We spoke with four patients on the ward during the inspection. We also spoke with two people who had been patients on the ward in the previous nine months.

All of the patients and former patients were positive regarding nursing staff. Staff were described as

‘magnificent’, ‘fantastic’, ‘very gentle’ and ‘really good’. Patients said staff got to know them and cared for and supported them. All of the patients felt safe on the ward. However, two patients told us that staff did not always knock on their bedroom door before coming in.

# 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?

This inspection focused on specific areas of safety, such as nursing staff vacancies, use of restraint and the assessment of patient risks. We did not re-rate this key question which remains as requires improvement. We found:

- Nursing staff did not always follow current infection control procedures and guidance concerning COVID-19.
- Nursing staff had not received training in the safeguarding model of conflict management which had been introduced the previous year. This meant individual staff members may have different levels of knowledge and understanding about safeguarding. This could impact on the ability of staff to anticipate and manage patients' distress or conflict.

However:

- Staff dealt with patient conflict, aggression and distress by verbal de-escalation. There had been no recent incidents of the physical restraint of patients and restraint was used as a last resort.
- Staffing arrangements ensured consistency of care. Staffing vacancies were covered by long-term agency staff.
- Staff assessed potential risks to patients when they were first admitted. The ward had appropriate procedures for the management of risk when patients were first admitted to the ward. The level of staff observation of patients was based on individual patients' risk assessment.

### Are services caring?

This inspection focused on whether patients felt supported and safe. We did not re-rate this key question which remains as good. We found:

- Two patients said that staff did not always knock on their bedroom doors before entering their bedrooms.

However:

- Staff treated patients with compassion and kindness. Patients were complimentary regarding nursing staff and how they were cared for.

## Detailed findings from this inspection

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

Safe

Caring

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

### Safe and clean environment

#### Maintenance, cleanliness and infection control

Nursing staff did not always follow current infection control procedures and guidance concerning COVID-19.

Four nursing staff were in the nursing office at the beginning of the inspection visit. None of the nursing staff were wearing face masks and the size of the office did not allow for social distancing. This meant any potential risks of COVID-19 transmission amongst staff were not adequately controlled. Staff did not follow the personal protective equipment guidance published by Public Health England and NHS England (June 2020).

### Safe staffing

#### Nursing staff

Staffing arrangements ensured consistency of care. Staffing vacancies were covered by long-term agency staff.

The ward had eight registered nurse posts, of which two were clinical team leaders. There were four vacant posts (50%) at the time of the inspection, including both clinical team leader posts. However, the service had recruited to a clinical team leader post and a registered nurse post. These new staff were awaiting the completion of recruitment checks. The ward also had 19 support worker posts. There were no support worker vacancies at the time of the inspection.

Agency nurses were used on the ward to cover the vacant registered nurse posts. These agency nurses had worked on the ward almost all of the time for more than two years. They received supervision and provided supervision for more junior staff. In effect, the agency nurses undertook the same duties as permanent registered nurses. This provided consistency to the care of patients.

When the number of patients requiring continuous observation exceeded normal staffing, additional agency staff worked on the ward. Wherever possible, staff ensured these agency staff had worked on the ward previously.

### Assessment of patient risk

Staff assessed potential risks to patients when they were first admitted.

Patient referral information was reviewed by one of the registered nurses prior to their admission to the ward. When patients were admitted they were assessed by a registered nurse. This included an assessment of patients' potential risk behaviour and their physical health, using the Modified Early Warning Score (MEWS). After the nurses' assessment, a doctor would assess patients, including their level of risk. Outside of normal weekday working hours, the on-call doctor would assess patients.

### Management of patient risk

The ward had appropriate procedures for the management of risk when patients were first admitted to the ward. The level of staff observation of patients was based on individual patients' risk assessment.

Patients admitted to the ward were continuously observed by nursing staff until the doctor had completed their assessment. Patients' level of observation by staff was based on the registered nurse' and doctors' assessment of patient risks. In practice, patients' levels of observation were either intermittent, four times per hour, or continuous observation. Documentation for intermittent observations had recently been changed. Instead of set times, every 15 minutes, printed on the observation records, staff now recorded the actual time they observed patients. This meant that intermittent observations were now undertaken at regular times, which is recommended best practice (Mental Health Act Code of Practice, 2015).

On the day of the inspection, eight patients were continuously observed by staff. Patients were continuously observed by staff for a number of reasons, including for physical health reasons. The high level of continuous observations also reflected the rapid turnover of patients.

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

Patients were admitted directly from the community and were often transferred back to their local NHS Trust in a short period of time. This meant that many patients on Byron Ward were in the most acute phase of their illness.

A large poster on the ward advertised that Byron Ward was a 'safeward'. Safewards is a model of working to minimise incidents of conflict and violence. Byron Ward had become a 'safeward' the previous year. However, staff had not received any training and were expected to learn about safewards themselves. This meant individual staff members may have different levels of knowledge and understanding about safewards. This could impact on the ability of staff to anticipate and manage patients' distress or conflict.

## Use of restrictive interventions

Staff dealt with patient conflict, aggression and distress by verbal de-escalation. There had been no recent incidents of the physical restraint of patients and restraint was used as a last resort.

In the nine months from October 2019 to June 2020, staff had restrained patients on 45 occasions. Seven of these involved restraining patients in the prone position. The months when the most restraints took place were in January 2020 (17 restraints on eight patients) and October 2019 (14 restraints on four patients). There had been four restraints of patients since February 2020, with none in May or June 2020. Between October 2019 and June 2020, patients had been restrained on 12 occasions for staff to administer rapid tranquilisation.

All of the staff we spoke with described how they attempted to verbally de-escalate patients when they were angry, frustrated or distressed. They described the importance of good communication skills when doing so. Patients were only offered additional medicines when this was necessary. All of the staff we spoke with said that the physical restraint of patients was avoided wherever possible and that there had been no restraints on the ward for some time.

The hospital had a restrictive interventions reduction programme. Byron Ward was part of this programme and all restrictive interventions were monitored.

## Are acute wards for adults of working age and psychiatric intensive care unit services caring?

### Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness.

We spoke with four patients during the inspection. We also spoke with two people who had been patients on the ward in the previous nine months.

We observed several interactions between staff and patients. Staff communicated with patients sensitively, displaying interest and compassion. Staff provided patients with help and emotional support. On some occasions, staff and patients engaged in light-hearted conversations and joked together, displaying warmth and mutual respect. During interviews, staff described the importance of building professional relationships with patients.

All of the patients and former patients were positive regarding nursing staff. Staff were described as 'magnificent', 'fantastic', 'very gentle' and 'really good'. Patients said staff got to know them and cared for and supported them. All of the patients felt safe on the ward. However, two patients told us that staff did not always knock on their bedroom door before coming in.

All of the staff we interviewed felt they were able to raise concerns with the managers. This included staff abusing patients or behaving unprofessionally.



# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider **MUST** take to improve

- The provider must ensure that all staff always use personal protective equipment as recommended by Public Health England and NHS England. Regulation 12(2)(h).

### Action the provider **SHOULD** take to improve

- The provider should ensure that staff always knock on patients bedroom doors before entering.
- The provider should consider structured training and support for staff to effectively implement the safeguards model on the ward.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment