Cygnet Hospital Blackheath

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

Cygnet Hospital Blackheath provides psychiatric intensive care and low secure care to men over the age of 18 years.

As this was an unannounced, focused inspection we did not rate this service following this inspection. During the inspection we focused on staffing levels at night, staff members ability to raise concerns, if patients felt supported and safe, the culture of the ward and how the management team had responded to a number of serious incidents.

We undertook this inspection due to three incidents where staff allegedly assaulted patients and other staff allegedly failed to report such incidents. All of the incidents were on Tyler Ward, the psychiatric intensive care unit. The incidents were alleged to have taken place during the night.

At the time of the inspection, a police investigation was continuing and a small number of staff were not working whilst the allegations were being investigated by the provider.

We found:

- Allegations of staff assaulting patients were responded to promptly by the managers of the service. This included staff being suspended and incidents being reported to the local safeguarding team, the police and the Care Quality Commission. In some cases, the service also made referrals to the Nursing and Midwifery Council.
- The management team identified the need for a wide-ranging investigation and a number of the provider's central staff supported this. This included a review of restraint incidents, unannounced night visits and an investigation of patients' views. Actions taken following initial investigation findings included; all nursing staff to work day and night shifts and a new senior nurse role of night co-ordinator with responsibility to maintain standards of care and to ensure staff behaviour remained professional.
- Three of the six patients we spoke with were complimentary regarding nursing staff being helpful and treating patients well. The remaining half of patients found some staff to be good and others not. The provider's expert by experience lead also undertook an investigation of patient's views. An expert by experience is someone who has used, or cared for, someone using services. The expert by experience lead identified that patients generally found staff to be helpful and supportive and felt listened to when they complained.
- The nursing team had high levels of confidence and trust in the ward manager and their leadership style.

Summary of findings

- Following allegations of staff assaulting patients, all staff in the hospital had been asked to complete a 'closed culture' survey regarding the care and treatment of patients by staff. This survey aimed to identify if managers were accessible, staff were caring towards patients and if staff would report concerns. Ninety-three staff in the hospital (77%) responded to the 'closed culture' survey.

However:

- The 'closed culture' survey identified that whilst 93% of staff felt comfortable and confident raising concerns about patients' care, only 80% of staff felt comfortable and confident raising concerns about a colleague. This finding was concerning as some staff were alleged to have not reported incidents when staff assaulted patients.
- Some staff did not feel managers addressed and acknowledged concerns raised by them. Although there was a record of some acknowledgement of staff issues in meeting minutes, and managers said they were open to listening to concerns, not all staff could attend meetings and said they did not always have time to read the minutes.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Hospital Blackheath

Cygnet Hospital Blackheath has two wards. Tyler Ward is a 15 bed psychiatric intensive care unit and Meridian Ward is a 17 bed low secure ward. Both wards provide care and treatment to men over the age of 18 years.

Cygnet Hospital Blackheath 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 a registered manager in post at the time of the inspection.

We have inspected Cygnet Hospital Blackheath twice since 2015. At our last inspection in April 2018, we found the following breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 11 (need for consent) – medicines were not prescribed in accordance with law relating to consent to treatment under the Mental Health Act 1983

Regulation 12 (safe care and treatment) – the staff team did not reflect on their work together to ensure learning from frequent incidents

Regulation 18 (staffing) – staff did not receive appropriate supervision to enable them to carry out the role they were employed to perform.

At the April 2018 inspection we rated the hospital as requires improvement overall. We rated the psychiatric intensive care unit as requires improvement overall, along with requires improvement for being safe and effective. We rated caring, responsive and well-led as good. The low secure ward was rated good overall, and for all key questions except effective, which was rated requires improvement.

Our inspection team

The inspection team consisted of an inspector, an inspection manager and an assistant inspector.

Why we carried out this inspection

We undertook this inspection due to three incidents involving staff allegedly assaulting patients and other staff allegedly failing to report such incidents. All of the incidents were on Tyler Ward, the psychiatric intensive care unit during the night.

At the time of the inspection, a police investigation was continuing and a small number of staff were not working whilst the allegations were being investigated by the provider.

How we carried out this inspection

We undertook a night inspection visit to Tyler Ward. Due to COVID-19 we interviewed some patients and staff by teleconference.

As this was a focused inspection, we only looked at specific areas concerning staffing levels at night, staff members ability to raise concerns, if patients felt supported and safe, staff culture and how the management team had responded to a number of serious incidents

During the inspection visit, the inspection team:

Summary of this inspection

- visited Tyler Ward and observed how staff were caring for patients;
- spoke with six patients who were using the service;
- spoke with the ward manager;
- spoke with nine other staff members; including a team leader, registered nurse and support workers;
- looked at a number of operational documents concerning the running of the service

What people who use the service say

We spoke with six patients during the inspection.

Three patients were complimentary about the nursing staff. Nursing staff were described as 'very, very nice people' and 'fantastic'. These patients said that staff were helpful and treated patients well.

The other three patients said that some staff were good, but others were not. One patient explained that some staff were 'out to get' them and another patient said some staff were unhelpful.

Four patients said they felt safe on the ward. One patient was unable to answer if they felt safe and one patient said they felt unsafe on the ward. This patient explained that they had also felt unsafe at their previous hospital.

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 staffing levels at night, staff members ability to raise concerns and how the management team had responded to a number of incidents. We did not re-rate this key question. We found:

- The ward maintained safe staffing levels. Staffing levels for nursing staff had recently been reviewed and increased.
- Allegations of staff assaulting patients were responded to promptly by the managers of the service. This included staff being suspended and incidents being reported to the local safeguarding team, the police and the Care Quality Commission. In some cases, the service also made referrals to the Nursing and Midwifery Council.
- Seventy-nine per cent of staff had undertaken safeguarding adults training, Four of the five staff who were yet to complete the training had been employed recently and were due to complete this training during their induction.
- Following allegations of staff assaulting patients, all staff in the hospital had been asked to complete a 'closed culture' survey regarding the care and treatment of patients by staff. Ninety-three staff in the hospital (77%) responded to the 'closed culture' survey.

However:

- The 'closed culture' survey identified that whilst 93% of staff felt comfortable and confident raising concerns about patients' care, only 80% of staff felt comfortable and confident raising concerns about a colleague. This finding was concerning as some staff were alleged to have not reported incidents when staff assaulted patients.

Are services caring?

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

- Three of the six we spoke with were very complimentary regarding staff. They found staff to be helpful and said they treated patients well. The other half of patients said that some staff were good, and others were not.

Summary of this inspection

- An investigation by the provider's expert by experience lead found that patients generally viewed staff as helpful and supportive. Patients said they only felt unsafe due to other patients' behaviour. Patients knew how to make complaints and were confident these would be listened to.

Are services well-led?

This inspection focused on the culture of the ward and how the management team had responded to a number of serious incidents. We did not re-rate this key question. We found:

- The nursing team had high levels of confidence and trust in the ward manager and their leadership style.
- Ninety-five per cent of staff responding to the 'closed culture' survey felt the senior management team were regularly present in the service.
- Following a staff member whistleblowing to the Care Quality Commission, the management team arranged meetings with staff to understand staff members' concerns. A review of staffing levels and the referrals process followed these meetings. Managers were supportive of the whistleblowing process and reminded staff how to whistleblow.
- The management team had identified the need for a wide-ranging investigation following allegations of assaults by staff on patients. This included a number of the provider's staff and included a review of restraint incidents, an investigation of patient views and unannounced night visits by managers. Key decisions from the investigation included a new senior nurse post of night co-ordinator and all staff being required to work day and night shifts. This was to ensure standards of care and staff conduct were maintained throughout the day and night.
- The ward manager actively managed staff performance and addressed concerns regarding individual staff members.
- Staff morale had increased recently with the arrival of new members of nursing staff. This had, however, been affected by staffing pressures due to COVID-19 and the number of assaults on staff by patients.

However:

- Some staff did not feel managers addressed and acknowledged concerns raised by them. Although there was a record of some acknowledgement of staff issues in meeting minutes, and managers said they were open to listening to concerns, not all staff could attend meetings and said they did not always have time to read the minutes.

Detailed findings from this inspection

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

Safe	
Caring	
Well-led	

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

Safe staffing

The ward had enough nurses who knew the patients and who had received basic training to keep patients safe from avoidable harm. The ward was able to maintain safe staffing levels.

A number of staff, who often worked night shifts, were not at work at the time of the inspection. Four members of staff were either furloughed due to COVID-19 or were suspended from work whilst investigations were undertaken. A registered nurse had also been dismissed recently. However, staffing rotas showed that minimum safe staffing levels were maintained. At night there were a minimum of two registered nurses and two healthcare support workers. Registered nurses who were junior in terms of experience always worked with more experienced registered nurses.

The hospital had its own bank staff who worked regularly in the service. In addition, four agency registered nurses worked full time on Tyler ward. These nurses also received supervision and were able to undertake all of the duties of permanent staff.

There had recently been a high level of staff absence on the ward. This was due to staff members being ill or shielding from COVID-19. In addition, a number of staff had been off duty with injuries sustained after patients had assaulted them.

Staffing levels for the ward had recently been reviewed and increased. Staffing levels were based on the number of patients on the ward, with staffing increasing with the number of patients. When patients required continuous observations, staffing numbers were increased.

Safeguarding

Staff had completed training about how to recognise and report abuse and they knew how to apply it. The service worked well with other agencies to protect people from abuse.

This inspection was undertaken due to three alleged incidents of staff physically assaulting patients over a period of several months. These incidents were recorded on closed-circuit television installed on the ward. A member of staff reported the first incident to the ward manager. A patient reported the second incident. The third incident was discovered when managers were reviewing the closed-circuit television recording.

The management team had taken immediate action when they learnt about each of these incidents. This action involved suspending staff members who were alleged to have assaulted patients. Staff who had failed to report these incidents were also suspended. When agency staff were involved the agency was contacted and the hospital provided full details of the incident. The management team also reported all of the incidents to the local safeguarding adults team, the police and the Care Quality Commission. Where appropriate, and following investigation, the management team also referred some registered nurses to the Nursing and Midwifery Council, the professional regulator for nurses.

All of the staff we interviewed felt able to raise concerns. This included staff behaving unprofessionally towards patients. Staff were confident the ward manager would take such concerns seriously.

Following the incidents, the provider had conducted a 'closed culture' survey of all staff at the hospital. This included administrative and domestic staff. Eighty-nine staff (77%) in the hospital responded. Of these, 83 staff (93%) felt comfortable and confident that they could raise concerns about patients' care. Seventy-two staff (80%) felt comfortable and confident raising concerns about a colleague. Seventy-three staff (82%) felt their concerns would be listened and responded to. In the same survey, 77 staff (87%) considered staff behaved appropriately towards patients by being caring, tolerant and understanding.

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

Twenty-three nursing staff (79%) had completed safeguarding adults training. Four of the five staff who had yet to undertake the training had started working in the service in the previous month. These staff had a period of time to complete mandatory training alongside their induction in the service.

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 six patients during the inspection. During the inspection two patients were in the communal areas of the ward. We observed that staff spoke with patients kindly.

Three patients were very complimentary about the nursing staff. Nursing staff were described as 'very, very nice people' and 'fantastic'. These patients said that staff were helpful and treated patients well. The other three patients said that some staff were good, but others were not. One patient explained that some staff were 'out to get' them and another patient described the helpfulness of staff being based on their ethnicity.

Four patients said they felt safe on the ward. One patient was unable to answer if they felt safe and one patient said they felt unsafe on the ward. This patient explained that they had also felt unsafe at their previous hospital.

The provider's expert by experience lead had visited the service to undertake a service user feedback investigation. This involved interviews with patients and observation of how staff interacted with patients. The expert by experience found that feedback was largely consistent and that patients viewed staff as supportive, polite and friendly. Patients reported that when they felt unsafe this was due to other patients. Patients also reported that when staff restrained patients this was undertaken in a professional manner and was largely due to patients assaulting staff. Patients said they knew how to make complaints and that when they had raised issues in the past they had been listened to and managers were supportive of them.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles. Leaders had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.

The ward manager for Tyler Ward had a clear understanding of the ward they managed. They had significant clinical experience and understood how to deliver high quality care. Interviews with staff and the 'closed culture' staff survey demonstrated that the nursing team had high levels of confidence and trust in the ward manager and their leadership style.

The ward manager was supported in their role by the clinical services manager and the hospital manager. The 'closed culture' survey found that 95% of staff felt the senior management team were regularly present in the service. A number of staff who responded to the survey also made additional comments about the visibility of senior managers.

Culture

Overall, staff reported positively on how they were supported and listened to by managers. Managers actively promoted staff to use the whistleblowing process if they had concerns.

Overall, staff felt respected and supported in their roles, with the responses to the 'closed culture' survey supporting this view. The ward manager of Tyler Ward, the clinical service manager and the hospital manager were all commented upon positively by staff in the survey. However, two staff members reported that when they raised some concerns regarding staff issues these were not acknowledged by senior managers. The 'closed culture' survey contained some comments supporting this.

Examples provided by staff concerned the broken nursing office door and the use of personal protective equipment during the early stages of COVID-19. The minutes of team

meetings recorded that staff concerns were acknowledged. This included the effect on staff of patients who were sexually disinhibited and support available in the reflective practice group and from the psychologist.

Concerns regarding COVID-19 and personal protective equipment had also been acknowledged and managers said they were always available to address these concerns. Guidance on the use of personal protective equipment for staff had been confirmed at the time of the inspection. However, at the start of the COVID-19 outbreak, staff and managers had differing views regarding whether staff should have always worn face masks. Reasons for withholding the limited supply of personal protective equipment available at the time had not been effectively communicated to all staff. Due to nursing shift patterns, staff attendance at team meetings was variable. Although the minutes of team meetings were sent to all nursing staff, staff did not always have the time to read them.

Three months before the inspection, the Care Quality Commission received a whistleblowing concern from a staff member. The concerns raised included staffing levels and the high number of violent incidents on Tyler Ward. The management team responded by reviewing staffing and increasing the number of nursing staff on shift. The process for assessing referrals to the ward was also reviewed. The team meeting minutes recorded that all new referrals had to be assessed and discussed by at least two clinicians.

Following the staff member whistleblowing, managers had been available for individual meetings with staff to understand staff members concerns. Themes from these staff meetings were addressed openly during team meetings. The senior management team also ensured staff were aware of the whistleblowing posters and that staff knew who to contact to whistleblow. At a later team meeting, whistleblowing was again raised due to a change in the external company providing the service. Staff were reminded that the whistleblowing process was confidential.

The ward manager actively managed staff performance. They provided examples of addressing concerns and supporting staff with self awareness regarding how they communicated with others.

Staff and managers said the arrival of new staff members and a focus on team working had increased staff morale recently. This had, however, recently been affected by staff shortages due to COVID-19 and the number of assaults on staff by patients.

Governance

The management team initiated, used and reviewed a wide range of processes and governance systems to improve and maintain standards of care.

The management team took immediate action following the three incidents of alleged abuse of patients by staff. Staff members alleged to be involved, or who had not reported the incidents, were removed from contact with patients. The management team also informed relevant agencies of the allegations.

The hospital management team recognised that a wide-ranging investigation and review of Tyler Ward was required due to the serious nature of the allegations. This involved a number of individuals working for the provider involved in regional or corporate roles. The expert by experience lead interviewed patients and provided a thorough report on their findings. This included recommendations and constructive challenge. A human resources business partner commenced a staff clinic where staff could confidentially raise any concerns. The reducing

restrictive interventions lead began reviewing all restraint incidents in the previous 12 months. In addition to the hospital manager undertaking unannounced visits at night, the regional quality assurance manager undertook night shifts the weekend before the inspection. A 'closed culture' survey was also rapidly developed for staff.

Although some parts of the investigation were continuing, such as the review of restraint incidents, a number of actions had already been implemented from early investigation findings. The format for staff supervision had been revised and a decision had been taken that no staff would work predominantly night shifts. This was to ensure that standards of care and staff conduct were maintained throughout the day and night. In addition, a new role of night co-ordinator was developed. This meant a senior nurse would work every night in the hospital and would not be included in the nursing staff complement for either ward. Part of their role would be to maintain standards of care during the night.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all staff understand it is their responsibility to raise concerns regarding unprofessional and abusive behaviour by staff.
- The provider should ensure that key messages, including acknowledging and addressing staff concerns, are communicated to all staff in an accessible way.