Cygnet Hospital Sheffield

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

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.

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

Overall summary

We found the following areas of good practice:

- Staff were up-to-date with their mandatory training and managers monitored this weekly. Staff received training in the requirements of the Mental Health Act and Deprivation of Liberty Safeguards. Overall, staff compliance with mandatory training was high.
- Staff carried out restraint and seclusion only when necessary and could show how they took into account patient preference.
- Patients had comprehensive risk assessments which staff updated following incidents.
- Patients had a single complete and contemporaneous care record which contained up-to-date care plans and physical health monitoring. Staff used outcome measures appropriate to the patient group.
- Patients had meaningful involvement in their care and staff had a collaborative approach to care planning and risk management. Patients could get involved in decisions about the running of the hospital.
- Staff kept carers up-to-date with their relatives' progress and carers attended multidisciplinary reviews.
- The hospital had an improved complaints procedure. Patients and carers knew how they could complain and felt their concerns would be taken seriously.
- Managers had introduced new initiatives to improve the quality and safety of the wards. The hospital could show a reduction in the use of restrictive practices including restraint and seclusion.

Summary of findings

- Staff had made improvements to the environment and to the overall of quality of care. Most patients and carers were happy with the care provided by staff.

We found the following areas the hospital needs to improve:

- Managers did not always ensure that records demonstrated staff monitored medication fridge temperatures consistently and correctly.
- Some of the provider's policies did not provide enough guidance for staff on the standards expected of them.
- Staff did not record when de-brief occurred with staff or patients following incidents.

Although the provider had made improvements and addressed all the areas we told them they must do following our previous two inspections, we were not able to change their ratings. This was because this was a focussed inspection and we only inspected those areas which we required them to address following our last comprehensive inspection in August 2017 and our focussed inspection in September 2017.

Summary of findings

Contents

Cygnet Hospital Sheffield

Services we looked at:
Forensic inpatient/secure wards; Long stay/rehabilitation mental health wards for working-age adults; Child and adolescent mental health wards;

Summary of this inspection

Background to Cygnet Hospital Sheffield

Cygnet Hospital Sheffield is an independent mental health hospital providing low secure and locked rehabilitation services for women, and child and adolescent mental health services for male and female adolescents aged between 12 and 18. The hospital has capacity to provide care for 55 patients across four wards. These are:

- Spencer ward: 15 bed low secure adults ward for female patients.
- Shepherd ward: 13 bed long stay rehabilitation adults ward for female patients.
- Peak View: 15 bed mixed sex acute ward for children and adolescents. However, the provider could limit the number of admissions depending on patient acuity.
- Haven: 12 bed mixed sex psychiatric intensive care unit for children and adolescents.

The hospital had one registered manager for all four wards and the clinical manager acted as the controlled drugs accountable officer for the hospital. The hospital is registered to provide the following regulated activities: Assessment or medical treatment for persons detained under the 1983 Mental Health Act; diagnostic and screening procedures and treatment of disease, disorder or injury.

We undertook a comprehensive inspection of Cygnet hospital Sheffield in August 2017. Following that inspection we issued the provider with three requirement notices. These related to:

- Regulation 9 HCA (Regulated Activities) Regulations 2014: Person-centred care.
- Regulation 16 HCA (Regulated Activities) Regulations 2014: Receiving and acting on complaints.
- Regulation 17 HCA (Regulated Activities) Regulations 2014: Good governance.

We rated the hospital as requires improvement overall. We rated the domains of safe, effective, caring, responsive and well-led as all requires improvement. We told the hospital it must make a number of improvements and should consider making improvements in other areas where we identified shortfalls but which did not constitute breaches of the regulation. These can be found in our inspection report published in November 2017. Following this report, the provider sent an action plan setting out how they were going to meet the requirements of the regulations.

Following our comprehensive inspection, we carried out an unannounced focussed inspection on the acute adolescent ward, Peak view in September 2017. This was in response to two significant incidents. The inspection was not rated but the provider was issued with the following breaches;

- Regulation 12 HCA (Regulated Activities) Regulations 2014 safe care and treatment.
- Regulation 17 HCA (Regulated Activities) Regulations 2014 good governance.

We told the hospital it must make a number of improvements and should consider making improvements in other areas where we identified shortfalls but which did not constitute breaches of the regulation. These can be found in our report published in November 2017. The provider sent an additional action plan setting out how they intended to meet the breaches identified in that inspection.

We carried out a further unannounced focussed inspection at Cygnet Hospital Sheffield on both of the child and adolescents mental health wards: Peak View ward and Haven Ward because we had some concerns about patient safety. At that inspection, there were no regulatory breaches but we told the provider they should take some action to improve patient safeguarding plans and incident investigations. These can be found in our last inspection report published in February 2018. The provider sent an additional action plan setting out how they intended to make the improvements we told them they should take.

At this inspection, we found the provider had met the requirements in relation to regulations 9, person centred care, 16, receiving and acting on complaints, 17 good governance and 12, safe care and treatment.

Although the provider had made improvements, we were not able to change the ratings for this hospital. This is because this was a focussed inspection and we only

Summary of this inspection

inspected those areas which we required the provider to address following our last comprehensive inspection in August 2017 and our focussed inspections of September and December 2017.

Our inspection team

Our inspection team consisted of a team leader, one inspector and one assistant inspector from the Care Quality Commission. The team also included one specialist advisor who was a nurse consultant with experience in both adult and child and adolescent mental health.

Why we carried out this inspection

We carried out this inspection to establish whether Cygnet Hospital Sheffield had made improvements following our last comprehensive inspection where we rated them as requires improvement overall. We also reviewed the actions the provider had taken following our focussed inspections of Peak View and Haven wards. We did not rate this inspection.

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service and provider:

- is it safe?
- is it effective?
- is it caring?
- is it responsive to people's needs?
- Is it well led?

Before the inspection, we examined information that we held about the hospital. At the inspection, we assessed whether the service had made improvements to the specific concerns we identified during our last comprehensive inspection and the two subsequent focussed inspections.These related to the key questions of whether the service was safe, effective, caring, responsive and well-led.

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients;
- spoke with 15 patients who were using the service;
- spoke with six carers of patients currently using the service;
- spoke with the ward managers for each of the wards;
- spoke with 19 other staff members; nurses, support workers and senior managers;
- spoke with a commissioner of the service;
- attended and observed one hand-over meeting;
- looked at 20 care and treatment records of patients;
- looked at eight seclusion records;
- looked at eight restraint records;
- Looked at the hospital's complaints records;
- carried out a specific check of the medication fridges on three wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with patients on all four wards of the hospital and spoke with carers from the two adolescent wards. Overall, patients told us they felt involved in their treatment and staff took their individual preferences into account. Patients on the adult wards told us they had opportunities to be involved in decisions about the running of the hospital and could get involved with staff recruitment.

Patients on the adolescent wards told us staff knew how to support them at times of crisis and could contribute to their own risk assessments and risk management plans. Young people felt involved in their care plans including regular treatment and care reviews. One patient told us they were involved in helping to train staff.

Patients on both the adult and adolescent wards told us they knew who to complain to and that any complaints would be taken seriously by staff.

Most of the carers we spoke with felt the staff communicated well with them and kept them informed of their relative's progress. Overall, they felt involved in the care plan and felt the hospital was responsive in involving them in treatment reviews. Most of the carers we spoke with told us they had been given a copy of the hospital complaints leaflet or seen a poster in reception so they knew how to make a complaint if necessary.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following areas of good practice:

- Staff carried out resuscitation simulation exercises to test staff knowledge and skills in responding to medical emergencies.
- Staff were up-to-date with their mandatory training and managers monitored this weekly. The provider could show compliance rates of 100% for many courses.
- Staff used restraint and seclusion only where necessary. Staff carried out these interventions where possible in line with patient preference.
- Patients had comprehensive risk assessments which staff updated following incidents.
- Staff and patients were offered the opportunity for de-brief following incidents and staff could take part in reflective practice sessions.

We found the following areas the hospital needs to improve:

- Not all staff consistently recorded the temperature of the medications fridges. It was not always clear what action staff had taken when fridge temperatures were outside the recommended range.

Are services effective?

We found the following areas of good practice:

- Patients had a single complete and contemporaneous care record which contained up-to-date care plans and physical health monitoring.
- Staff monitored the side effects experienced by patients from their medication. They used outcome measures appropriate to the patient group.
- Staff took timely action in response to actions identified from Mental Health Act audits. A high percentage of staff had received training the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are services caring?

We found the following areas of good practice:

- Patients had meaningful involvement in their care and staff had a collaborative approach to care planning and risk management.

Summary of this inspection

- Patients could get involved in the running of the hospital, for example, staff recruitment and training.
- Staff kept carers up-to-date with their relatives' progress and carers attended multidisciplinary reviews.

Are services responsive?

We found the following areas of good practice:

The hospital had an improved complaints procedure. Patients and carers knew how they could complain and felt their concerns would be taken seriously.

Are services well-led?

We found the following areas of good practice:

- Managers and staff took part in regular meetings aimed at reducing restrictive practice. Hospital data showed restrictive practices including restraint and seclusion were on a reducing trend across all wards.
- Managers had introduced new initiatives to improve the quality and safety of the wards including revised recruitment procedures.
- Staff and commissioners thought the overall management and governance arrangements at the hospital had improved. There were noticeable improvements to the environment and to the quality of care provided to patients across all wards.

However, we found the following areas the hospital needs to improve:

- Some of the policies did not provide enough guidance to staff about what was expected of them.

Detailed findings from this inspection

Mental Health Act responsibilities

Following our last comprehensive inspection in August 2017, we told the provider they should ensure that ward staff act upon issues identified in Mental Health Act audits in a timely manner. As part of this inspection we looked at audits for the three months prior to our inspection and spoke with one of the Mental Health Act administrators. On the adult wards, the providers audit showed compliance with the requirements of the Mental Health Act was high and there was only one outstanding action in April 2018 which staff had completed in May 2018.

On the adolescent wards, the administrator attended handover meetings and kept a tracker of actions following audits. The administrator could escalate concerns to the senior management team as necessary though they had not had cause to do this in the three months prior to our inspection. Overall, the new system was improving the hospital's compliance with the requirements of the Mental Health Act and we confirmed this when we looked at the audits from the adolescent wards where staff had carried out actions in a timely manner following audits.

Mental Capacity Act and Deprivation of Liberty Safeguards

At our last comprehensive inspection in August 2017, the hospital had introduced mandatory training for all staff in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, only 35% of staff on Shepherd and 33% of staff on Spencer had completed this. On the adolescent wards only 4% of staff on Haven ward and no staff on Peak View ward had completed mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

At this inspection, the hospital supplied us with data to show that 100% of staff on both adult wards had completed training in the Mental capacity Act and Deprivation of Liberty Safeguards and on the adolescent wards, 80% of staff on Haven ward had completed their training and 100% on Peak View had completed their training. The staff we spoke with showed a good understanding of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that their resuscitation simulation procedures take account of the latest guidance issued by the UK Resuscitation Council concerning response times for automated defibrillation.
- The provider should ensure effective policies and procedures are in place to monitor medication fridge temperatures consistently and correctly. Procedures must provide staff with adequate guidance about how to carry out effective monitoring and where to document the actions taken when temperatures are out of range
- The provider should consider how they record staff and patient de-briefs so they can monitor uptake and share any lessons learned from them.