Cygnet Hospital Coventry

Quality Report

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

Overall summary

We did not rate Cygnet Hospital Coventry at this inspection because it was an unannounced focussed inspection to check if staff were supported to observe patients safely.

We found that new processes and practice had been introduced to reduce the time staff spent observing patients that meant they were less tired and staff took breaks from observing. The allocation of staff to observe patients was well planned and staff were positive about the changes.

However, the nurse in charge on both wards could not take a break as there was no night co-ordinator. Managers who had introduced the change on observing patients needed to monitor the impact on staff and the quality of care provided.

Summary of findings

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Summary of this inspection

Background to Cygnet Hospital Coventry

Cygnet Hospital Coventry is part of the Cygnet Healthcare group. The group provides health care nationally.

The hospital is purpose built, providing inpatient mental health care and treatment for women. It opened in April 2017. It has three wards and a transitional living unit attached to one ward. Dunsmore ward has 16 beds and is a psychiatric intensive care unit (PICU), however this was closed following the previous inspection in July and August 2019. Middlemarch ward has 16 beds and provides high dependency inpatient rehabilitation. St Mary's Court is attached to Middlemarch ward and has seven studio apartments providing transitional support. Ariel ward has 16 beds and provides care and treatment specifically for women with a diagnosis of personality disorder. Ariel ward also provides care and treatment for women with a diagnosis of disordered eating and personality disorder.

The hospital was last inspected in July and August 2019. This was a comprehensive inspection following concerns we had from the focussed inspection in June 2019. We rated the hospital at the previous inspection as inadequate overall. We rated safe, caring and well-led as inadequate, and effective and responsive as requires improvement.

The hospital was first inspected in October 2017, which was a comprehensive inspection. The hospital was then rated "requires improvement" overall, with a rating of good in effective and caring. A further comprehensive inspection was undertaken in June 2018. We rated the hospital 'good' overall and for each key question. A further focussed inspection was undertaken in June 2019 and did not produce a rating as it focussed on one ward only.

The hospital did not have a registered manager at the time of this inspection however an application to register a manager was in place.

Our inspection team

The team that inspected the service comprised one CQC inspection manager and one inspector. This was an urgent, short notice inspection, which meant we were not able to include a specialist advisor or an expert by experience.

Why we carried out this inspection

We carried out this inspection because we had concerns about the care and treatment being provided at Cygnet Hospital Coventry. This was an urgent, unannounced focussed inspection to look at these concerns. Hospital staff did not know we were coming. We carried out this inspection in the early hours of 18 February 2020 to check patients were safe.

How we carried out this inspection

This inspection was an unannounced focussed inspection to check if staff were supported to observe patients safely.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

Summary of this inspection

- Visited each ward at the hospital to observe how staff were caring for patients
- Spoke with seven staff including the nurse in charge on two wards
- We walked around each of the three wards and observed how staff were observing patients
- We reviewed the staff allocation and observation planner for Ariel and Middlemarch wards
- We looked at six patient observation charts.

What people who use the service say

At this inspection, all patients but one were asleep, and they were taking a drink before returning to bed, therefore we did not speak with patients.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not inspect or rate safe at this inspection.

- There were enough staff to safely observe patients in line with individual care plans
- There were no staff asleep on duty
- New processes and procedures were in place to support staff to safely observe patients
- Patient observation charts were completed and up to date.

However:

- There was no night co-ordinator which meant the nurses in charge of the wards could not take a break
- There was further work to be undertaken to fully embed the new way of working to support staff to observe patients safely.

Are services effective?

We did not inspect or rate effective at this inspection.

Are services caring?

We did not inspect or rate caring at this inspection.

Are services responsive?

We did not inspect or rate responsive at this inspection.

Are services well-led?

We did not inspect or rate well led at this inspection.

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

Summary of findings

Safe staffing

There were enough staff on duty to observe patients at this inspection. There was no night co-ordinator on duty therefore the nurse in charge could not leave the ward. There was one night co-ordinator who worked four days per week. The second night co-ordinator had left and was not replaced. Night staff were recently uncertain whether the night co-ordinator role was to be appointed to but now understood one would be recruited. This would ensure oversight of the whole hospital and support registered nurses to take breaks. However, there was access to a duty manager who was on call and could support the hospital in an emergency.

The ward manager on Middlemarch ward had left. We asked staff if a new ward manager had been appointed but they were unable to tell us because they did not now. Staff were concerned that they did not always get timely information about any changes regarding the service. Staffing levels including the quality of staff was raised as a concern. There were reports of patient on staff assaults but these had significantly reduced since the previous inspection in June and August 2019.

Assessing and managing risk to patients and staff

Following concerns raised by patients to staff and managers at the hospital about staff sleeping whilst observing patients, the managers had introduced a number of measures to improve safety of patients and address the culture of staff working nights. This included reducing the time staff were scheduled to observe each patient from 90 minutes to 60 minutes, allocating staff more effectively using a planner, addressing the responsibility of clinical team leaders and providing additional training.

On Ariel ward, five out of 12 patients were nursed on enhanced observations, meaning that at least one member of staff was with them in their bedroom, we saw the allocation of night staff was planned well. It meant that no staff were observing patients on their own consecutively. It did mean on occasions that staff would observe for two hours consecutively but one of these observations were carried out with another member of staff. Staff were allocated breaks from observing patients on top of their normal breaks. One patient who was transferred to a local acute hospital for care and treatment was supported by one member of staff, but two staff shared this responsibility by splitting the night shift. Managers were talking to the acute hospital about relieving staff for short periods to ensure they could get a break. This was an improvement on the previous practice of sending one member of staff for the whole night.

On Middlemarch ward, two out of seven patients were nursed on enhanced observations and we saw the allocation of night staff was planned according to the new model adapted by managers. However, on a couple of occasions, one member of staff would observe one patient for one hour then move to another patient on enhanced observations. Staff told us that this had not caused them any problems and was better than previously where they might be observing for three hours.

Staff explained that a support worker was allocated to 'float' around the ward and checked if staff were okay. Staff reported that patients had made comment that staff were able to meet their requests more quickly with the new system.

On St Marys Court, which is focussed on patients moving towards discharge, four patients were sleeping and one patient was on home leave. One healthcare support worker was allocated to work at St Mary's Court overnight but had access to the nurse in charge and staff on Middlemarch ward for breaks and support.

We saw no evidence of staff sleeping on the wards and were assured that staff knew how to observe patients safely. Staff were sensitive to the needs of patients sleeping and would use dimmed lights to ensure they could observe with minimal disruption to patients.

Staff were carrying out observations in line with patients' individual care plans.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Not included in report as existing enforcement action in place.

Action the provider SHOULD take to improve

- The provider should ensure that nurses in charge at night are provided with cover to take their breaks.
- Managers should continue to monitor the new way of working to safely observe patients by ensuring staff do not observe patients on a one to one basis consecutively.