Cygnet Health Care Limited

Cygnet Hospital Godden Green

Inspection report

Godden Green
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, 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?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

On 10 November 2020 the Care Quality Commission undertook an unannounced comprehensive inspection of Cygnet Hospital Godden Green. This was following a focused inspection carried out on 02 October 2020.

We had not previously rated acute wards for working age adults and psychiatric intensive care units at Cygnet Hospital Godden Green under our comprehensive methodology as it had opened since our last comprehensive inspection. At the time of this inspection only one ward was open, Castle ward, a psychiatric intensive care unit for females. Castle ward comprised of 12 en-suite bedrooms. At the time of the inspection there were six patients on the ward.

Our rating of Cygnet Hospital Godden Green stayed the same. We rated it as requires improvement because:

- Staff did not always use physical restraint as the last resort to manage behaviour. The service had not identified all environmental risks. Personal evacuation plans did not explain to the emergency services how to assist the patient to exit the ward in an emergency. A blanket restriction prevented patients keeping toilet paper in their bedrooms.
- Staff did not always respect the privacy and dignity of patients. Patients were not always actively involved in planning their care.
- Patients could not make private telephone calls on the ward. Patients did not have enough storage space, in their bedrooms, for all their belongings.
- The management team had not fully embedded the governance processes to ensure the ward procedures ran smoothly.

However:

- There was a new leadership team in place at the hospital who had the experience, knowledge and skills to manage the service.
- The ward environments were clean. The wards had enough nurses and doctors. Staff managed medicines safely 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 kept families informed about their relative's care.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Hospital Godden Green

On the 2 October 2020, we undertook an unannounced, focussed inspection of the female psychiatric intensive care unit. We carried out this inspection following an inspection of a Child and Adolescent Mental Health ward at the hospital, that has now closed, Knole ward. The service was planning to open Knole ward as a female acute ward. We found similar concerns around leadership across the hospital and returned to complete a comprehensive inspection.

Cygnet Hospital Godden Green is registered for the following regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983; treatment of disease, disorder or injury.

At the time of our inspection there was not a registered manager, a Hospital Director had been appointed and had applied to be registered with the Care Quality Commission.

How we carried out this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the provider MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the provider **must** take to improve

We told the provider that it must take action to bring services into line with Cygnet Hospital Godden Green's legal requirements. This action related to psychiatric intensive care unit.

The provider must ensure patients are able to make private phone calls either on their personal mobile phone or via ward phones. Regulation 10: Dignity and respect 10(1)(2)(a)

The provider must ensure staff knock and wait before entering patients' bedrooms, unless it is an emergency. Regulation 10: Dignity and respect 10(1).

The provider must ensure patients have enough space to store their personal belongings with in their bedrooms. Regulation 10: Dignity and respect 10(1)(2)(a)

The provider must ensure personal evacuation plans are individualised and contain information relevant to assisting the patient to leave the ward during an emergency. Regulation 12: Safe care and treatment 12(1)(2)(a)

The provider must ensure that all risks are identified on their environmental and fixed ligature point assessments, that staff are aware of the risks and know how to mitigate the risk. Regulation 12: Safe care and treatment 12(1)(2)(a)(b)

Summary of this inspection

The provider must ensure that potentially dangerous items are always stored securely. Regulation 12: Safe care and treatment 12(1)(2)(a)(b)

The provider must ensure staff re-assess and rate risk regularly to reduce un-necessary restriction on patients. Regulation 12: Safe care and treatment 12(1)(2)(a)

The provider must ensure that staff only use physical interventions as a last resort and only following the use of de-escalation techniques. Regulation 13: Safeguarding service users from abuse and improper treatment 13(1)(4)(a)

The provider must ensure that patients have adequate access to toilet paper. Regulation 13: Safeguarding service users from abuse and improper treatment 13(1)(4)(c)

We told the provider that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

The provider should ensure that all incidents are correctly categorised. Regulation 12: Safe care and treatment(1)(2)(a)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement

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

Requires Improvement

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

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

Requires Improvement

We rated it as requires improvement because:

- Although we found the service largely performed well, it did not meet legal requirements relating to safe care and treatment, meaning we could not give it a rating higher than requires improvement.

- Staff had not identified all environmental risks on the ward. Patients could lock themselves into a room where there was an unidentified fixed-point ligature risk. Staff had not identified an environmental risk in the seclusion room that a patient could use to injure themselves on and staff had not locked potentially dangerous items away in the activities room. However, the activity room is only accessed under staff supervision. Personal evacuation plans were not personalised and did not explain how to assist patients to leave the ward in an emergency. Patients told us and record showed that all patients could not keep toilet paper in their bedrooms and had to ask for it when they needed it, regardless of risk.

- Staff did not always use physical restraint as a last resort. Staff had assessed risks to patients and themselves and developed care plans that followed best practice for managing challenging behaviour. We reviewed nine incidents and found that overall staff managed incidents well. However, we reviewed the CCTV footage of two incidents that showed staff did not always use de-escalation techniques before using physical restraint. The management team had identified one of the incidents and taken appropriate action and took appropriate action when we advised them of the other incident. We did not review any seclusion records as staff advised us that there had not been any seclusions for three months.

- Staff did not categorise all incidents correctly. We found one incident that staff had recorded as sexually inappropriate behaviour when a patient had touched a member of staff's face. There was no explanation why this constituted sexualised behaviour.

- Staff did not always re-rate risk appropriately. Staff rated patients risk level daily, however we saw that patients remained on a higher risk rating despite a reduction in incidents. For example, we saw one patient had not had any incidents for 10 days but remained rated as high risk. This meant they remained on higher levels of observation without an identified clinical reason.

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

Requires Improvement

However:

- The ward was clean, well equipped, well-furnished and well maintained.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. Following our last inspection, the service had introduced a full induction programme for the staff team. At the time of the inspection there was limited use of agency staff and when used, it was staff who were familiar with the service and the patients. Agency staff completed an induction checklist on their first shift at the service.
- Overall staff understood how to protect patients 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. We saw that staff reported incidents to the local safeguarding team when they needed to.
- Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records, whether paper-based or electronic. The service used an electronic record system as the main patient record. Staff completed paper copies of some records that they uploaded to the electronic system when completed.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health. We reviewed all six patient's medicines records and saw that staff followed the correct procedure and practices for prescribing and administering medicine. The service had a clinic room that had the equipment that you would expect for this type of service. Care plans relating to physical health were of a good standard.
- Incident management had improved since our last inspection. Overall 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 patients honest information and suitable support. The service shared lessons learnt through governance meetings, staff meetings, a hospital lessons learnt newsletter and emails to staff.

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

Good

We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussions and updated as needed. Care plans reflected the assessed needs, were holistic and recovery-oriented. We reviewed five sets of patient records held on the electronic record system and saw that staff notes and care plans covered identified risks
- Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals and supervision. Managers provided an induction programme for new staff. Following our inspection on 02 October 2020 the management team had introduced a comprehensive local induction programme, all staff completed the induction programme regardless of how long they have worked at the hospital.

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

Requires Improvement

- 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 patients had good access to physical healthcare and supported patients to live healthier lives. Care plans we reviewed identified patients' treatment plans for both their mental and physical health needs.

- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward.

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients 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. In addition to weekly ward rounds, there was a regular heads of department meetings in place where patients care and treatment was reviewed.

- 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 patients' rights to them.

- Staff understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Staff had not given section 17 leave to patients that were rated low risk. Section 17 leave is the only way patients can legally leave hospital when detained under the Mental Health Act.

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

Requires Improvement

We rated it as requires improvement because:

- Although we found the service largely performed well, it did not meet legal requirements relating to dignity and respect, meaning we could not give it a rating higher than requires improvement.

- Staff did not always respect patient privacy and dignity. Patients complained that staff would come in to their bedrooms with out knocking. Staff had put signs on doors to remind them to knock. However, we saw that patients continued to complain about this to the Independent Mental Health Advocate.

- There was limited involvement of patients in their care planning and risk assessment.

However:

- The staff team understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Staff we spoke to could explain their role and how they used care plans to support the patients during their admission.

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

Requires Improvement

- Staff informed and involved families and carers appropriately. Families we spoke with told us that they received weekly calls from staff to advise them how their relative was doing. Families also told us that staff supported their relative to keep in contact when appropriate.

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

Requires Improvement

We rated it as requires improvement because:

- Although we found the service largely performed well, it did not meet legal requirements relating to dignity and respect, meaning we could not give it a rating higher than requires improvement.
- Patients could not keep all their personal belongings, including clothes, in their bedroom. This was because the bedrooms did not have enough storage for belongings brought to the hospital by patients.
- Patients could not use the ward telephone in private and staff told us that they needed to supervise patients when using their mobile phones. We reported this to senior managers and they took action to ensure patients could make private phone calls.

However:

- Discharge was rarely delayed for other than clinical reasons. The average length of stay was two months and we saw that staff started planning for discharge when patients were admitted.
- The design and layout of the ward supported patients' treatment and privacy. Each patient had their own bedroom with an en-suite bathroom. There were quiet areas for privacy. The ward had a large airy lounge and dining area that provided ample space for all patients and patients got regular access to fresh air. There were several rooms that patients could use as quiet areas, but the rooms tended to have specific functions such as sensory and activities rooms.
- 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. We saw that the service had a robust system in place to investigate complaints and report any action that staff needed to take. The Independent Mental Health Advocate had reported to the senior manager that some patients lacked confidence in making complaints. Following this managers had advised staff to provide patients with the informal complaints form, as soon as they expressed concerns. Staff would encourage patients to complete a formal complaint form if the patient was not satisfied with the initial response.
- The food was of a good quality and patients could make hot drinks and snacks at any time. The catering staff attended ward meetings so that they could get direct feedback from the patients.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

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

Requires Improvement

Requires Improvement

We rated it as requires improvement because:

- Although we found the service largely performed well, it did not meet legal requirements relating to the safe, caring and responsive domains, meaning we could not give it a rating higher than requires improvement.

- Governance processes were new and not fully embedded in to the service. We saw that governance systems identified issues and there was a clear pathway for staff to follow any identified actions. However, we also found issues that staff had not identified which demonstrated that the systems needed more time to embed. For example, staff had not identified all environmental risks.

- Not all staff felt that there were opportunities for career progression. Staff told us that the service provided training in response to issues rather than as part of a staff members personal development plan.

- At the time of our inspection the service was not involved in national audits or accreditations schemes. The service provider had suspended local audits due to the pandemic and was in the process of starting them again. For example, the blanket restriction audit was due in August 2020 but was delayed until November 2020.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. The new management team in place at the hospital had relevant experience and could explain the process they were taking to drive improvements at the hospital. They had developed a comprehensive action plan following our previous inspections which addressed our concerns and showed how they would improve the service. Staff we spoke to knew who the senior managers were.

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff told us that the service was undergoing changes and they knew what the planned changes were and why they were needed to improve the service.

- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution. The hospital director had started open sessions to give staff an opportunity to give direct feedback to the management team.

- Staff had access to the information they needed to provide safe and effective care and used that information to good effect.

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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Physical interventions were not always used as a last resort.** **Patient's access to toilet paper was subject by a blanket restriction.** **This is a breach of regulation 13: Safeguarding service users from abuse and improper treatment 13(1)(4)(a)(c)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Patients could not make private phone calls either on their personal mobile phone or via ward phones.** **Staff did not always knock and wait to enter patients bedrooms.** **The was not enough space for patients to store all their belongings in their bedrooms securely.** **This is a breach of regulation 10: Dignity and respect 10(1)(2)(a)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Personal evacuation plans were not individualised and did not contain information relevant to assisting the patient to leave the ward during an emergency.

Not all risks had been identified on the environmental risk and fixed ligature point assessments.

Not all potentially dangerous items were stored securely.

Daily risk assessment did not always reflect a reduction in a patients risk.

This is a breach of regulation 12: Safe care and treatment 12(1)(2)(a)(b)