Cygnet Hospital Ealing

Quality Report

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Date of inspection visit: 28 and 29 November 2018
Date of publication: 15/02/2019

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 re-rate this hospital as a result of this focused inspection. This was because we only looked at specific issues on one ward that staff and patients had contacted us about. We issued two warning notices immediately after the inspection telling the service it must make immediate improvements around the documentation and management of risk and the governance of the service. We will return to inspect the service shortly to ensure that actions taken by the provider are embedded and that patients at the service are safe.

We found:

- Sunrise ward did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Many of the patients were being supported using one-to-one observations. High numbers of temporary staff were used to carry out this role. This meant permanent staff, including registered nurses in charge of shifts, spent a disproportionate amount of time managing staff who were unfamiliar with the ward. This had the potential to impact on the quality and safety of patient care.
- Despite the high use of temporary staff there were still shifts with insufficient staff on duty to carry out one-to-one observations of all patients with an assessed need for this.
- Staff did not keep up-to-date and accurate records of patient care and treatment. Key information about risk was missing from patient records. This meant that information needed by staff to keep patients safe was not always available. This was a concern as many of the staff on the ward did not know the patients well and therefore relied on the accuracy of these records.
- The one-to-one observations were not recognised as a restrictive practice, so their use was not kept under careful review.
- Patient and carer feedback indicated that patients were not consistently listened to and provided with compassionate care by all staff.
- The ward did not have effective governance systems in place to monitor actions to improve the service. The hospital risk register and the CQC action plan did not accurately reflect work that still needed to take place.
- Staff had little opportunity to discuss learning from incidents, complaints and audits.
- Staff morale on the ward was low. Staff told us about divisions within the ward team and this affected the ability of staff to work together productively for the benefit of patients.

However:

Summary of findings

- Staff and patients were positive about the impact of the new ward consultant who had recently started at the service
- The service management along with the new ward consultant, were committed to the improving the care model provided within the service. We received positive feedback about the moves already taken to improve the service.
- Patients told us that there were some staff who responded to them with kindness and care.
- The service provided an independent advocacy service which patients were positive about.

Summary of findings

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Background to Cygnet Hospital Ealing

Cygnet Hospital Ealing is a hospital for women with two wards. For this inspection, we only visited Sunrise ward. Sunrise Ward is a ward for women with eating disorders who are over 18 years old. There are 17 beds and many patients share rooms.

The service is registered to provide the following regulated activities:

Care and treatment for people detained under the 1983 Mental Health Act

Treatment of disease, disorder and illness

The service has a registered manager.

The service was last inspected in May 2017, when both wards were inspected and it was rated good overall. At the inspection the hospital was issued with two requirement notices. One was for regulation 10 (dignity and respect) because we received poor feedback about the quality of care for patients and one was for regulation 17 (good governance) because learning from incidents was not evidenced in the minutes of staff team meetings and there was little evidence that issues raised in staff meetings and patient community meetings were used to drive improvements in the service.

Our inspection team

Our inspection team consisted of three inspectors and one specialist advisor who was a nurse with experience working in an eating disorders service.

Why we carried out this inspection

We inspected this service in response to information we received about it, in order to follow up concerns raised.

How we carried out this inspection

Before the inspection, we reviewed information we held about the service, including feedback about incidents, complaints and comments.

During the inspection visit, the inspection team:

- Visited Sunrise Ward and spoke to the Ward Manager
- Reviewed the ward environment including looking at information on display for patients and staff
- Spoke with eight members of staff, including nurses, health care assistants and other members of the multidisciplinary team
- Spoke with the Hospital Director and Clinical Nurse Manager
- Spoke with seven patients and three carers or family members of patients
- Spoke with the Regional Operations Director
- Spoke with the provider's regional lead for reducing restrictive practices
- Reviewed six care records including risk assessments and risk management plans.

We requested additional information during and after the inspection which we reviewed, including information about incidents, complaints, safeguarding referrals, audits and peer quality reviews

Summary of this inspection

What people who use the service say

During the inspection visit, we spoke with six patients and after the inspection we spoke with three family members. Patients gave us mixed feedback about support provided by staff and, while they could name some individual staff members who were supportive, they also told us about staff who had not responded to them in a sympathetic manner. They said there were times when staff had spoken about other patients in front of them and that they did not always feel able to raise concerns about the service as they did not feel assured their feedback would be listened to.

Family members told us that they had not been consistently involved in the care provided to their relative.

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 re-rate this service.

We found:

- Staff on Sunrise Ward did not always update individual patients risk assessments following significant incidents. This meant that staff might not have accurate information when making decisions that could impact on patient safety such as approving leave from the ward.
- Staffing on the ward did not always meet the provider's minimum level of nurses on duty or staff to carry out one-to-one observations to deliver safe care. The numbers of temporary staff on the ward, due to the high levels of one-to-one observation, was at risk of impacting the quality of care due to the additional time needed by permanent staff managing staff unfamiliar with the service.
- Staff we spoke with could not describe any systematic learning from incidents that had taken place locally or elsewhere in Cygnet Healthcare.

Are services caring?

We did not re-rate this service.

We found:

- Patient feedback about staff on Sunrise Ward was mixed. They said some staff were good, but others were not sympathetic to their needs.
- Patients raised concerns about receiving one-to-one supervision from male members of staff as they sometimes had to wait for female staff to become available for bathroom or toilet trips.
- Patients described how their privacy was invaded when they shared rooms with patients who received one-to-one observations when they did not.
- Families we spoke with told us that the service did not consistently communicate effectively with them and involve them in the care of their relative when their relative consented to this.
- Patient feedback during their community meetings was not followed up and patients were not updated about the progress of their requests from one meeting to the next.

Summary of this inspection

- The provider's expert by experience programme had been expanded to make it more relevant to patients on the ward since the last inspection, but was not yet embedded on the ward.

However:

- The service provided independent advocacy which was spoken of positively by the patients we spoke with.
- Patients were positive about some of the staff members working on the ward.
- The service had, with patient input, produced a booklet for staff new to the service.

Are services well-led?

We did not re-rate this service.

We found:

- Systems in place to monitor the quality of the service and drive improvement were not always effective. Information about audits and ward performance was not reliably communicated between the hospital leadership team and the ward staff.
- The hospital risk register and the CQC action plan did not accurately reflect actions and mitigations which had been taken to reduce the risks on the ward.
- Staff gave mixed feedback about leadership in the hospital with allegations of a senior member of staff shouting at other staff.
- Staff told us that there were divisions within the multidisciplinary team which were at risk of impacting on patient care.

However:

- The provider had appointed a new ward consultant who was providing clinical leadership and identifying areas for improvements in how the care was delivered to patients using the service.
- The provider had taken steps to work on some of the areas identified as being of concern.
- The provider had undertaken a recent quality review of the service which had identified some of the issues raised during the inspection visit and an action plan was in place

Specialist eating disorder services

Safe	
Caring	
Well-led	

Are specialist eating disorder services safe?

Safe staffing

The establishment staffing levels on the ward were determined by the provider's staffing matrix which linked the numbers of patients on the ward to the number of staff. The hospital senior management team told us that three nurses and five healthcare assistants were the minimum required for 15 patients.

However, we saw that in November 2018, there were eight day shifts where there were only two nurses on the rota and one night where there was one nurse on the rota to work. On one shift a student nurse had been included as a registered nurse according to the rota. This meant that on these occasions the ward did not have the required number of nurses on duty to meet its own assessment of safe staffing levels.

The hospital director told us that there were no concerns regarding staffing on the ward. However, we observed that the nurse in charge of the shift and other permanent nurses had to spend a large proportion of their time allocating observations, arranging breaks and generally managing the many bank and agency staff brought on to the ward to carry out one-to-one observations. This diverted them from their other clinical duties.

There were insufficient staff on some shifts to carry out one-to-one observations. On 18 November 2018 there were five patients on one-to-one observation. There were two registered nurses and six support workers on duty during the day, when, according to the ratios we were told were in place for the ward, there should have been three nurses and nine support workers on this shift. On 13 November 2018, there were four patients on one-to-one observation and one nurse and six support workers on duty during the day. There should have been three registered nurses and eight support workers on duty to support this level of need if the ward was working to the staff / patient ratios they said were in place. This meant patients who were not receiving one to one observation may be at risk of not having sufficient staff time available. One patient told us that they sometimes felt they needed to self-harm to be placed on one to one to receive sufficient staff input.

One member of staff, who was on the ward for the first time, had been asked to observe a patient before any form of orientation to the ward. We heard the substantive nurse in charge asking another member of staff to show them where the toilets and fire exits were when they had their break. This demonstrated a health and safety induction had not taken place before the new member of staff supported patients.

Staff reported to us that there were times when the ward struggled to find cover, particularly in relation to registered nurses. Two members of the permanent nursing staff told us that they had been asked to come in when off-duty because agency nurses were not trained in naso-gastric feeding.

There were two vacancies for registered nurses at the time of our inspection and two temporary vacancies as two nurses were not currently working. Another nurse was due to leave the month after our inspection visit. Together, these factors meant there was a risk that there were insufficient suitably qualified, competent and experienced members of staff available to carry out patient care.

We saw that in the 12 months prior to the inspection visit, 14 members of nursing staff (nurses and health care assistants) had left the service and 14 members of nursing staff had been recruited. Seven of those who had started had left within the same year. The hospital risk register acknowledged that staff retention, particularly for newly recruited nurses, was an issue.

Assessing and managing risk to patients and staff

We checked six individual patient risk assessments and daily risk management plans. The service had a mixture of paper and electronic records. Risk assessments were

stored in paper files and each patient also had an electronic record which displayed the immediate risk level and management plan on a front page with additional information, including daily progress notes.

The six daily risk management plans we saw were not updated daily. We saw that two of the records had out of date information about detained patients' authorised leave arrangements under the Mental Health Act. This meant that there was a risk that staff may not have the correct information about patients' entitlement to leave.

We saw that one of the risk assessments had not been updated after a recent significant incident. When we asked a nurse about this, they told us they had left a message for night staff to complete the risk assessment and we saw this in the communication book in the office, but it had not been completed two weeks after the incident. The incident review also stated that the risk assessment had been updated but this was not the case. This meant that there was a risk that current information was not available to staff on the ward and that messages including key information like updating clinical notes, were not consistently followed up when a message was left for a subsequent shift.

At the time of our inspection, there were eight patients who were on one-to-one observations. We asked for information about the number of patients on one-to-one observations throughout November and saw that there had been an average of six each day throughout the month, with the lowest recorded number being four on one day and the highest recorded number being eight on two days.

Staff on the ward did not recognise one-to-one observations as a restrictive practice on the ward. We found that, whilst staff were aware of the reducing restrictive practice programme at Cygnet Hospital Ealing, there was little awareness that one-to-one observation was a restrictive practice that should be kept to the minimum level required to ensure patient safety. A restrictive practice information board on the ward for patients did not mention the reduction of one-to-one observations as a key tenet of reducing restrictive practices on the ward. After the inspection, we spoke to the regional lead for reducing restrictive practice in Cygnet. They told us that while they had provided some support and had oversight of hospitals where levels of one-to-one observations were high, Cygnet Hospital Ealing had not routinely flagged as having a high level of one-to-one observations.

Cygnet's policy on reducing restrictive practices stated that the multidisciplinary team should regularly review the use of them. In the patient records, we did not see regular reviews of one-to-one observation levels. Cygnet's policy stated that these reviews should be documented. A peer review report which had been undertaken in the month prior to the inspection also recommended that these reviews should be documented.

Levels of enhanced observation levels were noted in hospital-wide clinical governance meetings and recognised as a restrictive intervention. However, this information about work towards the reduction in restrictive interventions which was discussed in the clinical governance meetings was not shared in ward operational meetings. This meant that there was a risk that the emphasis on the reduction of one-to-one observation as a restrictive intervention was not transferred from the hospital management to the ward-based staff. The lack of regular documented reviews meant that there was a risk patients were subject to more restrictive interventions than were always necessary.

Track record on safety

Between 1 November 2017 and 29 November 2018, 239 incidents were reported for the hospital. Of these, 194 were categorised as 'no harm', 37 as 'minor' and eight as 'moderate'. We reviewed the moderate incidents and found they had all been reported to CQC as required.

Reporting incidents and learning from when things go wrong

While staff reported incidents, there was not a culture within the ward of learning from things that went wrong. We did not find any evidence that incidents which could lead to broader understanding and learning were discussed regularly with relevant staff members. We reviewed monthly minutes from three ward operational meetings and learning from incidents did not feature. Staff were able to tell us about some recent incidents they had been involved with on the ward but it was not clear that

steps had been taken to embed learning from incidents that occurred on the ward or in other relevant parts of the organisation. This meant there may be a risk of reoccurrence.

The provider produced a monthly learning from incidents newsletter which was on display in the nurses' office but the lack of opportunity to discuss them as a staff team meant that the evidence for learning from incidents was not robust. One member of staff, who was part of the multidisciplinary team, confirmed they did not routinely discuss incidents in the service.

Are specialist eating disorder services caring?

Kindness, privacy, dignity, respect, compassion and support

At our previous inspection of this service in May 2017, we raised concerns that the feedback received from patients was consistently negative. During this inspection, this continued to be a concern. We spoke with seven patients who gave mixed feedback. Three of the six patients we spoke with told us that they felt it was difficult to make complaints or raise concerns. They gave two reasons for this, either they felt they were not taken seriously or because they did not want to get staff into trouble.

Two patients raised concerns about the use of male staff to carry out one-to-one observations. They said this meant they could not use the bathroom or toilet spontaneously as they had to wait for female members of staff to be available.

Patients we spoke with told us that they had access to advocacy services and were very positive about the support from the advocate.

Two patients told us that they had not been given any choice about who they shared rooms with and that this had been difficult when the other patient was more unwell than they were and needed one-to-one observations. They felt they were also under observation in these circumstances.

After the inspection we spoke with three family members of patients using the service. They told us that staff in the unit did not share information with them. They gave us mixed feedback about staff attitude in general; some staff were considered to be very good but others were not. One told us they had observed a member of staff speaking to a patient in a way that was not compassionate or thoughtful.

Involvement in care

At our previous inspection in May 2017, minutes from patient community meetings were not consistently recorded or accessible to patients. We also noted that issues raised by patients during the meetings were not responded to or replied to in a timely manner. We found this continued to be the case at this inspection.

Patients had opportunities to feed back about their experiences of the service at weekly community meetings which were facilitated by an independent advocate and this was confirmed by the minutes. On the day of our inspection, the minutes from the most recent meeting were not on display, but older minutes from October 2018 were on display There was a 'we said, you did' board on the wall, but the 'we did' actions were not clearly described. When we reviewed the community team minutes covering the six months prior to the inspection, we saw the ward advocate, who chaired each meeting, now took the minutes as well. However, clear actions, the person responsible and the due date for completion were not always recorded. For example, in a meeting on 29 June 2018, patients asked for chairs to be put on the balcony, this was followed by a further request on 10 August 2018 and there was no indication in the minutes how this had been followed up.

Patients gave us mixed feedback about involvement in care planning and discharge processes. Most patients told us that they were involved in developing, or aware of, their care plan. One patient told us they were unaware of their care plan and two other patients told us they did not always receive copies of their care plan.

While Cygnet had a 'People's Council' which sought to involve patients across the country, this was not a development which had reached Cygnet Hospital Ealing. Therefore, patients on Sunrise Ward were not yet routinely involved in developing strategies for the organisation and the ward. However, patients had been involved in putting together a booklet for temporary or new staff. The booklet covered both general ward information and information specific to an eating disorders unit.

At our inspection in May 2017, we met an expert by experience who we were told would be more involved in

work with the ward. At this inspection, we saw there had been little progress with this initiative. This meant that co-production through the expert by experience programme was not yet fully implemented at the ward level.

Are specialist eating disorder services well-led?

Leadership

The hospital was managed by a hospital director and a clinical nurse manager who had oversight of the unit. There was a ward manager who was based on Sunrise Ward. The month prior to the inspection, a new ward consultant had been appointed. The service was actively working to improve the clinical model. Staff and patients were positive about the impact of the new consultant.

Leaders at a local level had a good understanding of the ward's performance against criteria set organisationally and were able to explain how key performance targets were met.

Staff had regular contact with the hospital leadership team as they were visible on the ward.

Culture

Staff within the hospital provided us with mixed feedback about the hospital leadership team. Some staff told us they felt able to raise concerns and the hospital management would respond appropriately. However, other staff told us they did not feel the hospital leadership team was supportive. Three members of staff told us that they had witnessed other staff being shouted at by senior leadership within the hospital.

Staff told us about a split in the staff team between nursing staff and other members of the ward multidisciplinary team. Patients also told us about the split as they had overheard staff talking about it. These divisions were reflected in the weekly ward operational meeting minutes. They indicated that some nursing staff used the meeting time to raise concerns about other members of staff within the hospital. The provider was in the process of setting up awaydays for the staff group to discuss team dynamics. However, at the time of the inspection the ward culture was not consistently positive and therapeutic.

Cygnet Healthcare had a staff recognition scheme. We saw that in community meetings, ward operational meetings and clinical governance meetings, time was put aside to provide positive feedback to staff and there was also a space on the 'you said, we did' board in the ward which displayed this.

Governance

At our previous inspection in May 2017, governance was an area of concern because it was not clear how issues relating to the ward's performance were shared from the leadership team on site to staff based on the ward. This continued to be a concern at this inspection.

Information did not flow between different meetings, so there was a risk that relevant people did not have full access to all the information they needed to carry out their job and improvements would not be embedded in daily practice. We reviewed minutes from the hospital clinical governance meetings, the ward operational meeting minutes and the patients' community meeting minutes. There was no clear evidence that key information, for example, about learning from incidents, was passed on to the ward-based staff. In addition, while positive patient feedback was discussed, negative feedback was not. While some information was displayed on the walls, such as the monthly learning from incidents newsletter, we found little evidence of opportunities for discussion.

The hospital had an action plan based on the areas for improvement identified during the previous inspection in May 2017. The version we saw during this inspection was updated in August 2018. We found some of the actions identified as completed had not been completed, so the action plan did not hold accurate information. For example, one 'completed' action required learning from incidents to be discussed at ward operational meetings, but we found no evidence this had happened.

After the inspection, we asked the service to provide us with audits of the quality of care plans and risk assessments over the twelve months prior to the inspection. We were provided with four audits, undertaken in November 2017, December 2017 and January 2018 and most recently in September 2018. We could not find any evidence that actions and learning identified through the audit process had been communicated to the staff team.

Between 1 November 2017 and 30 November 2018 there had been 30 complaints relating to Sunrise ward. Nine of

these complaints related to attitudes of staff, communication or quality of care. Two of these complaints were upheld, three were partially upheld and four were not upheld. We asked for further details about the investigations into some of these complaints following the inspection but this information was not provided to us. We saw that while the number of complaints was discussed during hospital clinical governance meetings, themes and learning were not recorded and information was not cascaded to ward operational meetings to improve the quality of the service.

We saw that managers within Cygnet Healthcare had carried out an internal peer review shortly before our inspection visit. We checked this information on site and saw that some of the concerns identified during this inspection had been picked up during this visit. There was an action plan in place to ensure that some of these issues were addressed. This meant that the organisation had some oversight of concerns relating to the operation of the hospital.

After the inspection, we raised concerns with the provider who was responsive and took immediate action to ensure the service was safe.

Management of risk, issues and performance

The hospital held a risk register. We saw that the risk register already reflected most of the concerns we had identified. However, some of the actions which had been recorded as completed or underway were not evident in practice. For example, audit findings were meant to be used to improve record keeping with a completion date of November 2018. We visited at the end of November, but this action was not near to completion.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that risk assessments and daily risk information reflects the current patient risk (Regulation 12 (1) (2) (a) (b)
- The provider must ensure information about authorised leave (section 17 leave) for patients detained under the Mental Health Act (1983) is accurately reflected in care records. (Regulation 12 (1) (2) (a) (b)
- The provider must ensure that staff who work on Sunrise Ward have the opportunity to learn from incidents, audits, complaints and feedback in order to improve ward practice. (Regulation 17 (1) (2) (a) (e) (f)
- The provider must ensure that there are sufficient qualified, experienced nurses on duty and that they have the skills to work with patients with eating disorders. (Regulation 12 (1) (2) (c))
- The provider must ensure there are sufficient staff to carry out one-to-one observations for patients with an assessed need for this. (Regulation 12 (1) (2) (c))
- The provider must ensure that the governance systems in place, such as the risk register and CQC action plan, accurately reflect the work being carried out to improve the ward. (Regulation 17 (1))
- The provider must ensure that patient feedback is listened to and responded to in a timely manner. (Regulation 17 (1) (2) (e))
- The provider must ensure that patients subject to one-to-one observations have prompt access to the toilet and bathroom with support from a member of staff of an appropriate gender. (Regulation 10 (1)
- The provider must ensure that all reasonable steps are taken to maintain the privacy of patients who are not subject to one-to-one observations in their bedrooms. (Regulation 10 (1)
- The provider must ensure work on reducing restrictive interventions recognises the use of one-to-one observations on Sunrise Ward to ensure that when this is used, it is appropriate and the least restrictive intervention possible. (Regulation 12 (1))
- The provider must ensure that culture and morale within the ward team is addressed, multidisciplinary working relationships are improved and professionalism is promoted. (Regulation 17 (1) (2) (a) (e))

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 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance