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

Overall summary

We carried out an unannounced focussed inspection at Cygnet Hospital Sheffield on both of the child and adolescents mental health wards: Peak View ward and Haven Ward. Since September 2017 we became aware of a number of incidents and safeguarding concerns on Haven and Peak View wards which gave us concern about patient safety. We requested further information from the provider about how these incidents and safeguarding concerns had been managed. The information we received did not give us sufficient assurance to ascertain whether patients were suitably protected from harm. As a result, we undertook this focussed inspection to review the areas of safeguarding and incident management on the child and adolescent wards in further detail. This inspection was not rated.

During the inspection we found:

- The majority of staff on both wards were up to date with mandatory safeguarding training and staff were in the process of undertaking additional training. Staff reported knowledge and confidence about identifying and reporting safeguarding concerns. Contact with the local authority and actions to help safeguard patients were documented in patient records. From a review of seven patient's care records, we found one instance where a disclosure had not been reported and documented as required.
- Staff discussed safeguarding issues and incidents in a number of forums. These included staff meetings, specific safeguarding training and development meetings, multidisciplinary meetings and staff handovers. Patients with ongoing safeguarding concerns had safeguarding care plans in place. These were reviewed regularly but did not always contain details of ongoing safeguarding incidents on the ward.
- The hospital had recently introduced an incident review meeting so that managers had a daily discussion about all incidents which took place, any actions required and whether these needed to be notified to external organisations. We saw evidence of learning from serious incidents and staff told us about changes that had been made as a result of these. Managers had introduced new measures to improve information sharing about incidents and any associated learning.

However:

- The hospital held a safeguarding tracker to log progress of all safeguarding referrals centrally. This was incomplete in some areas and the data did not coincide with incident data recorded on the central tracker. Following our inspection, the provider told us this had been in the process of being updated due to being a recent implementation

Summary of findings

- Staff meeting minutes included evidence of some discussion of incidents, but did not demonstrate that learning from incidents were reviewed as a matter of routine. Some staff felt they did not get feedback or information about other incidents at the hospital which may be relevant. An investigation of a serious incident had exceeded the provider's own recommended timescales.

Summary of findings

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Background to Cygnet Hospital Sheffield

Cygnet Hospital Sheffield is an independent mental health hospital that provides low secure and locked rehabilitation services for women; and child and adolescent mental health services for male and female adolescents aged between 11 and 18. The hospital has capacity to provide care for 55 patients across four wards. These are:

• Spencer ward: 15 bed low secure ward for female patients

• Shepherd ward: 13 bed long stay rehabilitation ward for female patients

• Peak View ward: 15 bed mixed gender acute ward for children and adolescents

• Haven ward: 12 bed mixed gender psychiatric intensive care unit for children and adolescents

The hospital is registered to provide the regulated activities of: treatment of disease, disorder or injury; assessment or medical treatment for persons detained under the 1983 Mental Health Act and diagnostic and screening procedures.

The hospital manager had applied for registration as the manager to the Care Quality Commission. A registered manager is responsible for managing the regulated activities at the service. The manager's application was still in progress at the time of our inspection.

We last undertook a comprehensive inspection of Cygnet Sheffield in August 2017. At that time we rated the service as 'requires improvement' overall. Subsequent to that we undertook a focussed inspection of Peak View ward, the acute ward for children and adolescents, in September 2017 which was not rated. The actions we required the provider to take are included within the published reports of those inspections. Following these inspections we received action plans from the provider which we are monitoring and will continue to follow up as necessary.

Our inspection team

The inspection team consisted of three Care Quality Commission inspectors from the mental health hospitals directorate

Why we carried out this inspection

This inspection commenced on 20 December 2017 and was unannounced. It took place over one day and was focussed on both children and adolescent mental health wards, Haven and Peak View.

The inspection was prompted in part by a number of incidents and safeguarding concerns on Haven and Peak View wards that we became aware of since our last inspection in September 2017. We requested further information from the provider about how these incidents and safeguarding concerns had been managed. The information we received did not give us sufficient assurance to ascertain whether the patients on these wards were suitably protected from harm. As a result, we undertook this focussed inspection to review the areas of safeguarding and incident management in further detail.

The inspection was focussed on specific aspects of the child and adolescent mental health wards in relation to the key questions of 'is the service safe'. We did not rate this inspection.

Summary of this inspection

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

During this inspection, we focused only on relevant issues that had led us to undertake the focussed inspection. These were relevant to the key questions of 'is the service safe'. Before the inspection, we reviewed information that we held about the hospital in relation to Peak View and Haven ward.

This inspection was unannounced which meant no one at the service knew we would be attending. At the time of our inspection there were 10 patients on Peak View ward and eight patients on Haven ward. During the inspection visit, the inspection team:

- visited both Haven ward and Peak View ward and observed how staff were caring for patients
- spoke with eight patients across both wards
- spoke with the ward managers of Haven ward and Peak View ward
- spoke with the safeguarding lead for the hospital
- spoke with eight members of staff on both Haven and Peak View wards including nurses and support workers
- attended and observed a daily incident review meeting
- attended and observed a multidisciplinary meeting on Peak View ward
- reviewed the care and treatment records of seven patients
- reviewed a range of documentation relating to the running of the service

What people who use the service say

We spoke with eight patients across both wards during our inspection. Four patients told us they felt safe on the ward. Two patients told us they sometimes felt safe and sometimes did not. They attributed this to physical assaults or behaviour they had experienced from other patients. One patient felt unsafe but said this was due to their mental health condition and not related to the care they received. Another did not give a view of how they felt.

Patients said that where they had experienced or witnessed abuse from, or between other patients, that staff intervened. Most patients felt staff managed the incidents well and took action to prevent further incidents.

Patients told us, and were able to describe, abuse and the types of incidents that would constitute abuse. They told us they would speak out if they became aware of any abuse. This included telling staff members, a parent, family members and an advocate.

Two patients on Peak View ward said there were not enough staff and recounted incidents which occurred where they said staff were unavailable to assist and they had intervened. We reviewed this information and found a report where a patient had alerted staff about an incident and staff dealt with the situation appropriately. The patient subject of the incident was under regular observations which had taken place as required. Patients had variable experiences and views of the staff. Most said staff were caring and good to talk to and two named individual staff members they liked. Two patients said they felt some staff members did not care.

Patients on both wards knew about their care plans and what information was contained within these. Two patients on Haven ward told us about specific information in these they had helped to write. One patient on Peak View ward said they had not seen their care plan but that they probably had one.

Summary of this inspection

Most patients we spoke with who had been involved in incidents and who had been restrained said they received debriefs and felt staff action had been proportionate. One patient said they did not have any discussion following incidents.

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 that:

- Staff on Peak View ward, and the majority of staff on Haven ward, were up to date with mandatory safeguarding training. The safeguarding lead was in the process of delivering additional training to all staff about the safeguarding reporting process.
- Patients with ongoing safeguarding concerns had safeguarding care plans in place which were reviewed regularly. These did not always include current details about ongoing safeguarding incidents on the ward and not all staff knew who had them in place. Staff were familiar and knowledgeable about patient dynamics and safeguarding incidents from handovers and multidisciplinary meetings.
- Staff reported knowledge and confidence about identifying and reporting safeguarding concerns.
- Contact with the local authority and actions to help safeguard patients were documented in patient records. From a review of seven patient's care records, we found one instance where a disclosure had not been reported and documented as required.
- Staff discussed safeguarding issues and incidents in a number of forums. These included staff meetings, specific safeguarding training and development meetings, multidisciplinary meetings and staff handovers.
- The hospital had recently introduced an incident review meeting so that managers had a daily discussion about all incidents which took place, any actions required and whether these needed to be notified to external organisations. We saw evidence of learning from serious incidents and staff told us about changes that had been made as a result of these.

However:

- The hospital held a safeguarding tracker to log progress of all safeguarding referrals centrally. This was incomplete in some areas and the data did not coincide with incident data recorded on the central tracker. This meant the system was not fully reliable to give an accurate overview of safeguarding concerns and referrals.
- The hospital had introduced new measures to improve information sharing about all reported incidents with associated learning. However, although staff meeting minutes

Summary of this inspection

included evidence of some discussions of incidents, they did not demonstrate that incidents were discussed as a matter of routine and some staff still felt they did not get feedback or information about other incidents at the hospital which may be relevant

- The provider was completing an investigation of a serious incident investigation and this had exceeded the expected timescales in line with their policy.

Child and adolescent mental health wards

Safe

Are child and adolescent mental health wards safe?

Assessing and managing risk to patients and staff

At a prior focussed inspection of Haven ward in July 2017, we identified some shortfalls with the hospital's safeguarding systems. At our comprehensive inspection in August 2017 we found the provider had made improvements in this area. However, following a request we made to the provider for details of reports of incidents that had occurred since September 2017 on the child and adolescent wards, we were not assured that all incidents and safeguarding concerns were being managed appropriately. This was due to limited information within the reports and limited evidence of subsequent actions undertaken following incidents. This also included an instance of a staff member not reporting a safeguarding disclosure made by a patient at the time it was disclosed.

At inspection we found the service provided training to help ensure staff had the knowledge required to safeguard children and young people. All staff completed safeguarding training as part of their induction and this was refreshed annually. At the time of our inspection, the provider's data showed all staff on Peak View ward were up to date with their required safeguarding training for children and adults.

On Haven ward, 85% of staff had completed safeguarding adults training levels one and two and 93% had completed safeguarding children levels one and two. Eighty one percent had completed safeguarding level three which included safeguarding both children and adults.

The lead social worker operated as the main safeguarding lead for the hospital. The safeguarding lead had recently started to provide further safeguarding training to all staff by holding weekly three hour sessions. They had compiled a 'safeguarding check list' document. This included step by step guidance of how staff should deal with any safeguarding concerns including actions they should take, documentation to complete, and which people and agencies to inform. The training was also to guide staff about how to deal with historical disclosures patients may make. Staff we spoke with told us they had either had this extra training or were due to shortly undertake it. Both ward managers of Haven and Peak View wards felt that staff had gained a better understanding about how and what to report as safeguarding concerns following this training.

Staff had resources to help enable them to identify safeguarding concerns and take appropriate action. Staff described different types of abuse they would report and gave examples of prior safeguarding incidents on the ward. There was information present to inform staff who to contact about safeguarding concerns. Each ward had a safeguarding chart on display in the nurse's office which gave the names of the hospital's safeguarding links, co-ordinators and leads. It included contact details for external organisations such as the local safeguarding hub and local police service. Staff had access to safeguarding policies on the hospital's intranet system. The noticeboards in the patient lounges included information about safeguarding leads, advocacy services and a national helpline. This meant patients had access to information about other external agencies to whom they could report any concerns.

The safeguarding lead had oversight of safeguarding reports and were responsible for liaising with the external local authority where required. They told us they had support and regular communication with the corporate safeguarding lead for the provider.

The hospital had systems to help identify patients with safeguarding needs. Patients with ongoing safeguarding concerns had care plans present to help inform staff what support they required. These had been compiled by a member of the social work team with the patient. However, whilst staff were aware of patient dynamics and interactions and this information was shared in handover meetings and ward rounds, these safeguarding did plans did not always include safeguarding incidents such as where patients were involved in repeated altercations with another patient. The majority of staff we spoke with were able to state which patients had safeguarding care plans but not all support workers were confident about who had one in place.

Staff told us they discussed safeguarding concerns in various forums. These included multidisciplinary meetings, team meetings and handovers. They gave specific

examples of actions that were taken such as patients having their observations levels increased due to incidents with other peers. We observed a morning multidisciplinary meeting on Peak View ward. This was attended by the ward manager, a doctor, teacher, social worker and the nurse in charge. The meeting included a discussion about a patient who had made a recent safeguarding disclosure and actions staff needed to take to help safeguard them. The hospital had informed the police about the disclosure who attended on the day of our visit to see the patient.

The hospital held two weekly safeguarding training and development meetings. Individuals invited to attend included the hospital and clinical manager, ward managers, social work team, a member of the education department, safeguarding link workers and the physical health team. We saw minutes of the last six meetings. These were detailed and showed that the team discussed safeguarding concerns, training, shared learning and serious case reviews. There were discussions about measures to try to safeguard patients. For example, about how to educate patients about cyber bullying, internet safety and boundaries between patients.

There was evidence of staff contact with the local authority and documented actions taken to safeguard patients where safeguarding incidents or disclosures took place. One patient on Haven ward had made a disclosure about potential abuse. Entries on the patient's records showed that staff had taken appropriate action. However, it was not evident from review of the records that staff had made a formal safeguarding referral to the local authority. There was no incident report of the allegation and no entry about a referral being made. We received assurance from the provider subsequent to our visit that these actions had been taken and they acknowledged this had not been correctly documented.

There was a system to log all safeguarding incidents centrally in the form of a safeguarding tracker. We requested a copy of the current tracker the hospital had in place. This included incidents starting from December 2017. The tracker was not fully completed as some sections including the outcome section, progress updates, whether the concern was escalated and the date the referral was closed by social care were not completed for the majority of the entries. Some safeguarding incidents on a separate incident spreadsheet that staff reviewed in the morning meeting were not included on the safeguarding tracker. Following our inspection, the provider told us this had been in the process of being updated due to being a recent implementation.

The provider's safeguarding children and young people policy stated that an incident form must be completed for all safeguarding children incidents and a serious incident notification sent to the corporate risk manager. There was no evidence to show that this had taken place. These findings meant there was a risk the provider did not have an accurate overview of all safeguarding concerns and outcomes, or a suitable system in place to maintain this overview.

Track record on safety

The hospital had systems in place to report and investigate serious incidents. Since our comprehensive inspection of August 2017, the provider notified us of a serious incident on Haven ward in early September 2017. The provider had completed an initial 24 hour report of the immediate actions undertaken, followed by a root, cause analysis investigation completed by someone external to Cygnet hospital Sheffield. At the time of this inspection, the hospital had not received a copy of the investigation outcome report. The provider's policy for incident reporting and management stated that they expected internal investigations to be completed within 40 working days of instigation date. As the provider had passed this timescale this meant there could be extra delays to sharing and implementing any recommendations and findings from the investigation. Following our inspection, the provider told us the delay had been due to unforeseen circumstances.

There was evidence of learning from a serious incident that had occurred earlier in the year. Staff we spoke with were aware of the serious incident which had taken place and described some specific examples of changes that had been made as a result. An independent external investigation into this serious incident in June 2017 had been completed in November 2017. The clinical manager told us they were working towards the implementation of an action plan to address the recommendations in the report. These were in addition to changes and improvements the hospital had already implemented following the incident.

Reporting incidents and learning from when things go wrong

Child and adolescent mental health wards

The hospital had a system to regularly review all incidents. Ward managers attended a daily morning incident meeting along with the hospital manager, clinical manager, quality and compliance manager and the safeguarding lead. This meeting was a recent introduction implemented by the hospital management. We attended and observed this meeting on the day of our visit. Each manager gave an overview of their ward's incidents which were incorporated onto an incident tracker spreadsheet during the meeting. Following the summary of the incidents, the team discussed whether any safeguarding actions had been undertaken, or were required, and whether the incident required notifying to any other bodies. For example, whether it met the criteria to report under NHS England guidelines or to the Care Quality Commission. If any further actions were required, these were documented so they could be reviewed to ensure they were completed.

The hospital manager, clinical manager and adolescent ward managers said the introduction of this meeting each day was useful. It enabled open discussion of incidents and helped give oversight to all staff present about incidents on other wards that. This assisted with consistency of reporting so that all wards were operating to same thresholds and reporting criteria.

Feedback from incidents was not consistent but the provider had identified this as an area to improve. Some staff said they did occasionally review incidents such as in debriefs and reflective practice where staff could look at what went well and what they could do differently. Other staff told us they did not always hear feedback from incidents; sometimes when they had specifically requested feedback on the system when submitting an incident report. Some staff told us they did not always hear about incidents on the other adolescent ward. They felt it may have been useful to know about these due to the similar patient group. The provider had recently implemented a process called 'red top alerts' to help share feedback and learning. These consisted of an alert which would highlight a particular incident or incidents and any immediate learning. These were to be circulated to each ward and shared with staff. None of these alerts had been formally shared at the time of our visit. Subsequent to our inspection, the provider shared two alerts with us which were generated from recent incidents and had been shared with staff.

Managers told us that learning from incidents was discussed as a staff team and in supervisions where appropriate. Minutes from meetings which took place on Peak View ward included a section to discuss clinical issues and incidents. The ward manager of Haven ward told us they were going to implement these same meetings. Recent staff meeting minutes for both Haven and Peak View wards, showed discussions about some incidents but it was not always evident that formal learning was captured which staff could use to reflect on and help prevent recurrences. The managers told us that their intention was to include this a recurring agenda item at future meetings.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that systems in use to record and track data contain the necessary level of information required to give accurate information.
- The provider should ensure patients' safeguarding plans include a sufficient level of information relating to all relevant safeguarding concerns. All appropriate staff should be aware of patients who have these in place.
- The provider should aim to complete investigations of incidents and implement any actions in a timely manner and in accordance with their own policies. They should ensure ways of identifying and sharing learning from incidents are embedded, and use these to make improvements to the service.