Cygnet Health Care Limited

Cygnet Joyce Parker Hospital

Inspection report

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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?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We rated this location as requires improvement because:

- The service did not always provide a safe care environment. Staff assessed risk well, but it was not always managed well. The structure of the ward environment on Mermaid ward was not always safe for all patients and there was not a clearly designated female only lounge area on either ward. Staff did not always complete and record physical health observations properly. We saw staff had left keys and alarms unattended and not secure in the reception area. There were still a number of incidents taking place, although moderate incidents had reduced. Staff continued to tell us that not all staff were confident in managing incidents. There had been two incidents take place after our inspection that the service had not notified us about without delay.
- Not all staff had significant experience in working with young people in a hospital environment. The service had identified and planned extra training to support staff, but this needed to be completed.
- Not all staff understood competency and capacity issues relevant to the patient group they worked with. There were blanket restrictions in place, where restrictions not been assessed individually for each patient.
- The design, layout, and furnishings of the wards did not always ensure the hospital met all of the patients' needs.
- Our findings from the other key questions did not always demonstrate that governance processes operated as effectively as they should have done, and this sometimes affected the quality of treatment and safety of patients.
- Not all families and carers felt the hospital staff communicated with them as well as they could do and did not always provide them with all the information they required.

However

- The ward environments were clean. Staff followed policies and procedures to keep patients safe in the Covid-19 pandemic.
- The wards had enough nurses and doctors. Staff managed medicines safely and followed good practice in respect of safeguarding. Staff reported incidents and there was shared learning and debriefs after these.
- 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 engaged in clinical audit to evaluate the quality of care they provided.
- 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.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and had received training in this. Staff supported patients to make decisions about their care for themselves. Staff assessed and recorded consent and capacity.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.
- Staff planned and managed discharge well and liaised well with services that could provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Requires Improvement 	We rated the service as requires improvement because: The summary is contained in the overall summary at the beginning of the report.

Summary of findings

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Summary of this inspection

Background to Cygnet Joyce Parker Hospital

We carried out this inspection of Cygnet Joyce Parker hospital in line with our methodology for new core services. The hospital opened in October 2020.

We had recently carried out a focused inspection of Mermaid ward in February 2021 because of concerns that had been raised with us about the hospital. At that inspection we identified regulatory breaches and issued two requirement notices. We did not rate the service at our focused inspection. The requirement notices were issued about the following concerns:

- We did not find the ward environment was robust enough for all patients
- We did not find there were as many staff as the hospital had planned for, and not all staff were suitably skilled and confident to carry out their roles.

Cygnet Joyce Parker hospital is provided by Cygnet Healthcare Ltd. and the hospital provides care and treatment for children and adolescents between the ages of 12 and 18.

The hospital provided the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Treatment of disease, disorder or injury.

The hospital has two wards:

Mermaid ward, a child and adolescent psychiatric intensive care unit, this ward has 10 beds.

Dragon ward, a general Adolescent unit, this ward has 12 beds.

Mermaid ward opened on 3 November 2020 and Dragon ward opened on 15 February 2021.

Children and young people between the age of 12 and 18 could access the service and there was an Ofsted registered school onsite. The school opened in January 2021. Before this date there had been an offer of online education.

The hospital was previously known as Cygnet hospital Coventry. This hospital had been closed by Cygnet Healthcare in July 2020 and reopened as Cygnet Joyce Parker on 15 October 2020.

At the time of our inspection there were four patients on Mermaid ward and seven patients on Dragon ward.

What people who use the service say

We spoke to four patients during our inspection and six family members. Patients and family provided us with mixed responses about their views of the service.

Summary of this inspection

Patients told us the wards were clean and that staff followed processes to keep them safe from the COVID-19 pandemic. Overall, they felt safe on the ward, although one patient did not think the ward environment was robust and that patients could hurt themselves.

Two patients raised concerns about specific members of staff in relation to how they behaved towards them. We spoke to the hospital manager about this who investigated the concerns and agreed to feed back to us upon completion of the investigation. However, overall patients gave us positive feedback about staff and told us that staff were kind and caring, respected their privacy and worked in their best interests.

Patients said there were nurses available and that they regularly saw a doctor. Patients were involved in their treatment and could attend community meetings on the ward. Two patients wanted to see more activity on the ward, but we did see that activity had increased overall and that the hospital were in the process of recruiting staff to increase activity further.

Carers also provided us with mixed feedback. Five of the six carers told us their family member was safe on the ward although one carer raised concerns about their child's self-harm. Overall, carers and family told us staff were kind, caring and helpful. They were able to attend meetings about their family member's care where the patient agreed.

Not all carers were happy with the way the hospital communicated with them. Overall carers did not think they were given enough information in advance of their child being admitted to the hospital. Three carers said communication was not always effective and that this sometimes made organising a visit to the hospital difficult.

How we carried out this inspection

This inspection was unannounced, we did not tell the provider that we would carry out this inspection. During this inspection we looked at all the domains and key lines of enquiry. We visited both wards at this inspection.

Due to the COVID-19 pandemic, we tried to reduce our time on site at the hospital. We conducted most staff interviews by telephone. Two inspectors and a specialist advisor carried out a site visit. Our specialist advisor had experience of working in child and adolescent mental health services. An expert by experience worked remotely and spoke to families and carers by telephone.

During this inspection, we:

- spoke with four patients who were being cared for by the hospital
- completed telephone and face to face interviews with staff members including doctors, a social worker, psychologist, occupational therapist, and registered nurses and support workers
- looked at the quality of the hospital environment
- looked at eight patients' care and treatment records
- looked at all patients' medicine cards
- completed interviews of two senior managers, the registered manager and hospital manager
- spoke with the teaching staff who worked with patients
- looked at a range of policies, procedures and other documents relating to the running of the hospital.
- attended a morning meeting and a community meeting.

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

Summary of this inspection

Areas for improvement

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with legal requirements.

- The service must ensure that staff are suitably skilled and confident to keep the patients safe and should be trained and competent in the assessment of competence and capacity. **HSCA Regulation 18 Staffing (1)**
- The service must ensure that they notify the Care Quality Commission of notifiable incidents without delay.
- The service must ensure that there is suitable signage to indicate where the designated female lounges are located, and local protocol identifies this as a need in line with the national guidance on mixed gender accommodation. **HSCA Regulation 17 Good governance (2) a**
- The service must ensure that staff are clear about how frequently they should complete patients' physical health observations and that they complete these accurately and fully.
- The service must make sure Mermaid ward is robust and safe so that patients are unable to damage the environment to cause harm to themselves or others.
- The service must ensure that keys and staff alarms are always secure. **HSCA Regulation 12 (2) d Safe Care and Treatment**
- The service must ensure that the ward environments were suitable to meet the needs of all patients. There was a lack of relevant information for patients and on Mermaid ward there was not an appropriate place for patients' faith needs. **HSCA Regulation 9 (1) a b Person Centred Care**
- The service must ensure that restrictions are individually risk assessed and suitable for each patient. **HSCA Regulation 13 (4) b Safeguarding Service users from abuse and improper treatment.**

Action the service SHOULD take to improve

- The service should ensure that staff evaluate all care plans and that these are written in the patient's voice.
- The service should continue to ensure families and carers are communicated with effectively throughout patients' treatment.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Requires Improvement

Child and adolescent mental health wards

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

Are Child and adolescent mental health wards safe?

Requires Improvement

We rated safe as requires improvement because:

- The ward environment on Mermaid ward was not always safe for all patients. Patients had been able to damage some of the fixtures and fittings. The provider had carried out some repairs and made changes to the ward environment to make it safer since our last inspection but there was still work to be completed. Further incidents had taken place where patients were able to damage the ward environment.
- At this inspection, we saw that several staff keys and alarms had been left unattended in the reception area. Staff told us these items should not have been left unattended there.
- Staff did not always complete physical health observations properly. Staff were unclear about how often these should be done, and there was a lack of guidance about this. We saw that staff did monitor patients' physical health using the National Early Warning scores 2. Staff did take action when this was indicated as required but they did not always complete all elements of the observations required to score and assess patients' risk. This meant scores were not always accurate. Staff recorded patients' height and weight, but not body mass.
- We reviewed incidents that took place between 26 February and 15 March 2021. There had been a total of 162 incidents on Mermaid ward and 74 incidents on Dragon ward in this period. We saw incidents on Mermaid ward classed as' no harm' or 'minor' had increased but that moderate incidents had decreased compared to what we saw at our last inspection. However, some staff reported that not all staff were confident in managing incidents and still required support with this.
- Mermaid and Dragon ward both had blanket restrictions in place so that patients had to ask staff to make hot drinks and snacks. No patients had keys to unlock their bedroom doors, bedroom doors self-locked when closed. These restrictions had not been individually assessed for each patient.
- We saw bedroom doors were open at our inspection. We asked about how staff ensured patients and their belongings were kept safe. Staff told us they observed the bedroom corridor to ensure patients' safety and patients had locked cupboards for their belongings. However, after our inspection there was an incident where staff had not been in the bedroom corridor area and an incident took place which put a patient at risk. Following this, patients were encouraged to use the self-locking mechanism on bedroom doors and staff monitored the corridor area constantly.
- During the period after our inspection there had been two incidents that took place that the hospital had not notified us of without delay.

Requires Improvement

Child and adolescent mental health wards

- Since our last inspection the hospital had added signage on both wards to indicate there were separate female lounges, but staff said these had been removed by patients. The hospital had ordered signage that could be permanently attached to the door but at the time of our inspection there was no clear indication of a female only space. The hospital did not have a protocol that indicated there should be female only lounge space.

However:

- The service had enough nursing and medical staff. The provider had made improvements since our last inspection to ensure that there were enough staff on duty. The provider had an active recruitment plan for vacancies.
- Wards were clean and furnished. There were policies and processes in place to keep patients and staff safe from the COVID-19 pandemic. Staff followed good infection control principles and cleaning took place regularly. On Mermaid ward, there had been a safety incident with the seclusion room clock and a seclusion room mattress had been damaged. Suitable alternatives had been ordered and these were due to arrive. In the interim, staff took a clock with them if a patient was secluded so that patients could see this from the seclusion room.
- 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. Each ward had a safeguarding lead. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The service had recently employed agency staff so they could be assured that there were enough staff to keep patients' staff. However, most staff were permanently employed by the service and knew the patients. Staff received basic training and 88% of staff were compliant with mandatory training.
- Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. Staff followed the code of practice when using restraint and seclusion.
- Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Staff reported incidents and managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised. After incidents patients and staff were offered debriefs.

Are Child and adolescent mental health wards effective?

Requires Improvement

We rated effective as requires improvement because:

- Not all staff could explain their understanding of Gillick competence and did not understand when the Mental Capacity Act 2005 applied to young people. Staff had not yet received training in Gillick competence. This training was due to take place.
- Not all staff had significant experience in working with young people in a hospital environment. The service had identified that some staff required extra training and support and had plans in place for this. This included Open University courses about subjects relevant to the patient group and brief guides developed by a doctor.

However:

Requires Improvement

Child and adolescent mental health wards

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were holistic and recovery oriented. However, Mermaid ward staff did not always record when they had reviewed all care plans.
- 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.
- Since the hospital had opened, we saw that staff had used recognised rating scales to assess and record severity and outcomes. They had also participated in clinical audit and worked with similar services in the organisation to share best practice. The hospital was working towards approval by a national accreditation scheme to improve quality.
- Both ward teams included a full range of specialists based on the wards required to meet the needs of patients on the ward. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- 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.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and had received training in this.
- Staff supported patients to make decisions on their care for themselves.

Are Child and adolescent mental health wards caring?

Good

We rated caring as good because:

- Overall staff treated patients with compassion and kindness. Staff respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Two patients raised concerns about a member of staff had treated them but did not raise a formal complaint. The service was responsive and investigated this and shared their lessons learned.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Not all care plans were written in the voice of a young person, but patients told us they were involved with their care. Staff ensured that patients had easy access to independent advocates.

However:

- Not all families and carers felt the hospital staff communicated with them as well as they could do. This included giving families enough information when a patient was admitted and communicating about care and visits. We reviewed an audit of hospital communication with carers from the 1 March 2021 until 24 March 2021 and saw that the hospital monitored whether staff had communicated daily with families. The data indicated that staff did contact families and carers as planned. The hospital wanted to improve what it was able to offer families and carers and told us they had been restricted to telephone support due to the COVID-19 pandemic.

Requires Improvement

Child and adolescent mental health wards

Are Child and adolescent mental health wards responsive?

Requires Improvement

We rated responsive as requires improvement because:

- There was not a wide range of information displayed on the ward at the time of our inspection: There was no available information about issues that affected young people. There was no information displayed about how a patient could make a complaint or contact the CQC. Although this information was available for patients on the hospital web site. Staff told us that patients had removed the notice boards, and therefore some of the information was not available. The hospital ensured this information was displayed after we raised this with them at inspection.
- The faith room on Mermaid ward was inadequate. It was a very small space and was only furnished with a bean bag, prayer mat and Qu 'ran. It was not a suitable space for meeting all patients' needs and had no information to support patients of other faiths or with different spiritual needs. The hospital director told us that there were plans to move the faith room to a more suitable space.
- On Dragon ward the blinds had been removed as they were potentially a risk to patients, but this meant neighbours in the residential area surrounding the hospital could see in. The hospital had ensured that both suitable blinds and privacy screening was in place following our inspection.

However

- Staff planned and managed discharge well. They liaised well with services that provided aftercare and were assertive in managing the discharge care pathway. Since the service had opened patients did not have excessive lengths of stay and discharge was rarely delayed for other than clinical reasons.
- Staff facilitated young people's access to education throughout their time on the ward.
- Staff met most of the needs of the patients who used the service – including those with a protected characteristic. Young people told us food was of a good quality. Staff helped patients with communication and advocacy. Cultural and spiritual support was provided by local faith leaders.
- 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.

Are Child and adolescent mental health wards well-led?

Requires Improvement

We rated well-led as requires improvement because:

- Our findings from the other key questions did not always demonstrate that governance processes operated as effectively as they should have done and some of these issues were outstanding from our previous inspection:

The local protocol for single sex accommodation was not in line with national guidance. It did not identify the need for a female only lounge area. The hospital had not informed us of two incidents as required without delay.

The ward environments were not always suitable for patients, they did not always meet patient's needs. Mermaid ward environment was not safe for all patients. There were gaps in staff training and the management of risk.

Requires Improvement

Child and adolescent mental health wards

However, there were examples of effective governance. For example, there were relevant and effective meetings and learning from incidents and complainants.

However:

- Hospital and ward managers had the guidance and support of experienced clinicians to help build their knowledge and skills in managing the service. Leaders had appropriate management skills and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression.
- Staff said they felt able to raise concerns without fear of retribution. However, one member of staff had raised some concerns with us in the period following our inspection, but the provider explained they had discussed these with the provider afterwards. Hospital leaders had spoken to each member of staff to check on their wellbeing since the last inspection. If staff had any issues they wanted to discuss, managers ensured staff had a variety of ways to speak to them including via the Freedom to Speak up Guardian.
- Ward teams had access to the information they needed to provide care and used that information to good effect.
- Staff engaged actively in quality improvement activities. For example, the hospital had started to work working to achieve accreditation with a national body.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Not all staff were suitably skilled and confident to keep patients safe. Staff had not been trained in Gillick competence.

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service had not ensured that the ward environments were suitable to meet the needs of all patients. There was a lack of relevant information for patients and on Mermaid ward there was not an appropriate place for patients' faith needs.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service had not ensured staff were clear about how frequently they should complete patients' physical health observations or that they completed these accurately and fully The service had not ensured that Mermaid ward environment was robust and safe for all patients. The service had not ensured that staff keys and alarms were always secure.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The service had not notified the CQC of two notifiable incidents without delay** **The service had not ensured there was suitable signage to indicate where the female lounges were located. The local protocol for mixed gender accommodation was not in line with national guidance.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The service had not ensured that restrictions were individually risk assessed and suitable for each patient.**