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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Overall summary

We carried out an unannounced focussed inspection at Cygnet Hospital Sheffield on Haven ward. The inspection took place to establish whether the hospital's systems and processes were suitably robust at night following a recent serious incident that occurred. We did not rate this inspection.

We found that:

- The hospital had suitable systems in place on Haven ward to enable staff to help manage risks to patients using the service. Staff were aware of known risks to young people and the hospital had processes in place to enable staff to escalate any concerns.
- Patients' care and treatment records on Haven ward had current risk assessments in place which staff regularly reviewed. However, we did see an instance where staff had not updated one patient's risk assessment in response to an incident.

Summary of findings

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Requires improvement

Cygnet Hospital Sheffield

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Summary of this inspection

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 is close to the city centre of Sheffield. Cygnet Hospital Sheffield was previously known as Alpha Hospital Sheffield until Cygnet NW Limited acquired all Alpha Hospitals in August 2015.

The hospital has capacity to provide care for 55 patients across four wards. These are:

• Spencer: 15 bed low secure ward for female patients

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

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

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

We last undertook a comprehensive inspection of Cygnet Sheffield in June 2016. We rated the service as 'requires improvement' overall. We rated the individual key questions as 'inadequate' for safe and as 'requires improvement' for effective, caring, responsive and well led. These ratings remain valid. The actions we required the provider to take are included within our previous report of that inspection.

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

There was a registered manager in post who was responsible for managing the regulated activities at the service.

Our inspection team

Our inspection team consisted of one Care Quality Commission inspector and two Care Quality Commission inspection managers from the hospitals mental health directorate.

Why we carried out this inspection

Since our comprehensive inspection of June 2016, we became aware of some concerns about the management of risks to patients on Haven ward. As a result, we carried out an unannounced focussed inspection at Cygnet Hospital Sheffield on Haven ward. The inspection took place to establish whether the hospital's systems and processes were suitably robust at night following a recent serious incident that occurred. We did not rate 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?

Summary of this inspection

Before the inspection, we reviewed information that we held about the child and adolescent wards. This information suggested that the ratings given in our June 2016 inspection were still valid.

During this inspection, we focused only on relevant issues that had led us to undertake the responsive inspection. These were relevant to the key question of 'is the service safe?' This inspection did not seek to revisit or address any issues or concerns identified in the comprehensive inspection of June 2016 where they were not relevant.

The inspection was unannounced which meant no one at the service knew we would be attending. During the inspection visit, the inspection team:

- visited Haven ward between 7:15pm and 11:30pm and spoke with six members of staff including nurses and support workers
- attended and observed a shift handover
- observed staff supporting patients
- offered all patients the opportunity to speak with us; however none chose to do so
- looked at the care and treatment records of four patients
- looked at a range of documentation relating to the running of the service

What people who use the service say

We offered each patient on Haven ward the opportunity to speak with us both privately, or in a group, during our visit. However, all chose not to speak with us.

Child and adolescent mental health wards

Safe

Are child and adolescent mental health wards safe?

Assessing and managing risk to patients and staff

The purpose of this inspection was to review the processes in place on night shifts for managing risks to young people on Haven ward.

We attended the service at 7.15pm in the evening. Access to the wards was via the reception area which was staffed by a receptionist. On entry to Haven ward, a child and adolescent psychiatric intensive care unit, we spoke initially with the designated nurse in charge of the shift. Staff we spoke with told us that there was always a designated nurse in charge on each shift. Staff told us they would report to the nurse in charge if they had any safety concerns. A hospital manager was on call each night if staff needed to escalate any concerns higher up or seek advice or support. At the end of each shift, the senior nurse on duty had to compile a status report which was circulated via email to the on call managers highlighting pertinent information from the previous night.

Staff handover occurred at 8pm when the night shift staff took over. We observed the staff handover which was led by the senior nurse on shift and attended by all staff on the oncoming night shift. Handover information was documented electronically and printed out for staff to review. We saw that staff had access to this information. Handover included comprehensive information about each patient on the ward. It included information about patients' risk history, current risks, physical health and plans of care in place for each young person. The senior nurse summarised information about the day's events, including any incidents and any changes in presentation of patients and discussed what care interventions they required. Individual patients observations were each allocated to a member of the night staff so that these could be consistently maintained.

Some staff on duty that night were not permanent Cygnet employees but contracted from an agency. All except one had worked on the ward before, some for a number of shifts. A permanent staff member was identified to help show these staff where to find necessary risk assessments and care plans on the ward. The team leader asked that the necessary staff read these before starting work. Staff who had been off duty in excess of two days prior to the shift were told which care plans had been updated and were asked to familiarise themselves with these updates.

All staff we spoke with told us that risks relating to young people were always discussed within each handover and they understood what support patients required to keep them safe. Staff could give examples of individual risks relating to young people. For example, we asked staff about the newest patient admitted to the service and known high risk patients; staff could describe specific risks pertinent to those young people. This matched risk information which we saw in care records. Staff were also aware of the recent serious incident that had taken place. At the time of our inspection, the incident was still being investigated by the manager in line with the procedure for serious incidents. Staff were aware of what had occurred and what extra measures had been implemented to keep the patient safe. At the time of our visit, this involved the patient temporarily being supported by three staff at all times to help manage their complex behaviour. We observed that staff ensured these measures were in place and saw the patient was supported in accordance with this. The patient spent time in communal areas interacting with other patients as they wished.

Staff knowledge was consistent about the protocols for where patients needed escorted leave, including for medical treatment, and what actions they would take. This included preference for treatment in the day time and also the use of familiar staff to accompany patients. Staff told us the senior nurse in charge would determine as to which staff would be used to escort patients. This would normally be substantive support workers unless there was a clinical need for nurses to attend and the skill mix would be adjusted to suit the need. New agency staff to the service would not be expected to undertake this role.

We looked at the care records of four young people on the ward. This included a review of care records for those with the most complex needs and most recently admitted to the ward. The provider used a recognised risk assessment known as the Salford tool for assessment of risk. We saw that risks were recorded, including risks from other services

and organisations that patients had transferred from and been in contact with for continuity. Risk assessments were current and subject to regular review and update. However, we found that staff had not reviewed or updated one patient's risk assessment following an incident in May 2016 until September 2016. Despite this delay, staff we spoke with were aware of the incident in May and the known risks for the patient.

There was safeguarding information on display in the wards so that staff were aware of who to contact for any safeguarding concerns. This gave information and contacts for the provider's key staff whom staff could consult for advice and the local authority who staff could report to. All staff we spoke with felt that the service was safe and that there were robust processes in place to address any concerns which may arise at any time.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that staff update all risk assessments as soon as practicable in response to incidents so that they accurately reflect current risks for each patient.