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

Are services safe?

Overall summary

We carried out an unannounced focussed inspection at Cygnet Hospital Sheffield on Haven Ward following a serious incident which had taken place. We identified a number of issues and shortfalls on Haven ward which gave us significant concern for the health and wellbeing of patients. As a result, we sent an urgent letter of concern to the provider highlighting our findings following the inspection. We requested that they provide us with assurance about what action they were going to take in response to our concerns.

The provider sent an action plan setting out what measures they had taken, or were taking, which we will follow up through further inspection. Following our inspection, the provider voluntarily closed Haven ward to further admissions. We did not rate this inspection.

During the inspection we found:

- There were shortfalls to the processes for individual patient risk assessment. There was limited information in care records about patients' risk warning signs, behaviours they may present with and what support each patient required to help manage these. Records and care plans did not always incorporate known risks relating to the patient. Some records contained several plans for the same areas of risk with differing levels of information.
- There was no consistent system to inform all staff about all newly admitted patients to the ward. The hospital operated two alternate shift groups at night with the same staff working in each shift. From staff accounts, there were differences in how they found out background information about patients admitted when they were not on shift.
- There were shortfalls in the reporting of, and learning from, incidents. Staff documented descriptions of incidents in patient's notes but had not always reported these on the incident reporting system. There was no evidence that any learning from incidents was

Summary of findings

being shared with staff at ward level. Staff did not routinely receive feedback about incidents unless these were serious and post incident debriefs did not always take place.

- Safeguarding procedures did not protect patients from the risk of exposure to harm. A number of reported incidents met the criteria for safeguarding but staff had not identified these or logged these as safeguarding concerns. Not all staff were knowledgeable about the ways they could report safeguarding matters, in particular, where these may occur out of hours.
- We were not assured patients were always protected from risk of discrimination. Some patients and carers felt staff did not always respect their needs, particularly in relation to their personal lifestyle choices. Patients had concern about some staffs' attitudes and comments towards them.
- Processes for staff engagement and observation of patients were not robust. Staff were expected to complete dual roles such as being part of the response team whilst still being responsible for patient observations. Some staff found difficulty in maintaining five minute observations. The allocation of observations did not always occur in accordance with policy. Not all staff were familiar with the policy or had received training in undertaking observations effectively.
- There were risks in relation to staffs' ability to respond to emergencies. There was no evidence of staff undertaking regular checks of emergency equipment. The latest emergency simulations on the ward showed improvements were required. All staff did not have access to necessary medical supplies such as dressings.
- Management of environmental risks was not robust. It was unclear what ligature risk assessment staff were expected to follow. There were repeated incidents of patients breaking through doors with little evidence of effective measures to try to prevent this. There were risks in the environment, such as access to screws in fixtures and fittings, which had led to repeated incidents of self harm by patients.

However:

- We observed that staff responded promptly to any incidents and patient feedback was that staff were good at helping to deal with these situations.
- Hospital management had already acknowledged shortfalls in adherence to patient observations and had started to address this by way of additional training.

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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: 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.

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.

At the time of this inspection the registered manager was not working at the hospital as they had left the service two months prior to the inspection but had not yet de-registered. A registered manager is responsible for managing the regulated activities at the service. An interim hospital manager, who was the substantive registered manager at another Cygnet hospital, was temporarily in post.

We last undertook a comprehensive inspection of Cygnet Sheffield in June 2016. At that time 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.

Following that comprehensive inspection, we undertook a further responsive inspection of Haven ward in October 2016 following a serious incident that had occurred. That inspection was focussed on specific aspects within the safe domain. This was not rated and there were no requirements for the hospital at that time. The overall rating for safe remained 'inadequate'.

Our inspection team

The inspection team was led by Care Quality Commission inspector, Anita Adams.

The inspection team consisted of two Care Quality Commission inspectors, including the team leader, and one inspection manager.

Why we carried out this inspection

We were notified about a serious incident that occurred on Haven Ward shortly before our inspection. This gave us concerns about the safety of the care and treatment of the patients on this ward.

We carried out an unannounced focussed inspection at night and over the following two days. The inspection was focussed on specific aspects of the service in relation to the key question of 'is the service safe?' We also took into account some further recent concerns that had been brought to our attention about the hospital, where these were relevant to the ward. 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 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. These will be followed up at a further comprehensive inspection of the whole hospital.

Before the inspection, we reviewed information that we held about the hospital where this was pertinent to the child and adolescent psychiatric intensive care unit, Haven ward. This information suggested that the ratings given in our June 2016 inspection were still valid.

This 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 7:00pm and 01.30am one night and spent time on the ward over the next two days
- spoke with the interim manager, clinical director and quality and compliance manager
- interviewed eight members of staff including ward managers, nurses and support workers which included a mixture of permanent and agency staff
- attended and observed a shift handover
- observed staff supporting patients
- spoke with six patients
- spoke with nine parents or carers of patients
- reviewed the care and treatment records of five patients
- reviewed a range of documentation relating to the running of the service

What people who use the service say

We spoke with six patients during our inspection on Haven ward during our visit and with nine parents and carers via telephone.

Patients told us they did not always feel safe, some attributing this to the recent serious incident which had made them feel very unsettled. They said when incidents occurred on the ward, staff were usually good at intervening and handling the situation. Four patients felt some staff comments were judgemental towards them, They told us there was little point raising this and other concerns as they would not hear anything back.

Most patients were aware of what observation levels they were on and of any restrictions in place to help manage their risks. They spoke about varying levels of involvement in their care planning with one patient saying they recalled no involvement.

All, except one patient, said staff numbers on the ward seemed suitable, however all commented on not knowing agency staff. They said some did not introduce themselves which did not help them to form relationships.

Feedback from parents and carers was mixed and the majority had both positive and negative experiences to report. Overall, six were mostly positive and pleased with the care Cygnet Sheffield provided. Two felt their child or relative had benefitted from being in the hospital and spoke about improvements from past placements they had been in. Three had predominantly negative views; two felt very strongly that the ward was unsafe. Recurring themes in most of the feedback were staff not informing them of incidents and contact with differing staff who they felt had little knowledge of their child or 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 found that:

- There was limited information in care records about patients' risk warning signs, behaviours they may present with and what support they required to help manage these.
- Care plans did not always incorporate known risks relating to the patient. Some records contained several care plans for the same areas of risk with differing levels of information which could have caused confusion.
- Staff documented descriptions of incidents in patient's notes but did not always report these on the incident reporting system.
- There was no evidence that any learning from incidents was being shared with staff at ward level. Staff did not receive feedback about incidents unless these were serious. Post incident debriefs did not always take place as only half of the staff said these occurred.
- A number of reported incidents met the criteria for safeguarding but staff had not identified or logged these as safeguarding concerns. Not all staff knew how to report safeguarding matters, especially out of hours.
- Some patients felt staff did not always respect their needs, particularly in relation to their personal lifestyle choices. Patients had concern about some staffs' attitudes and comments towards them.
- Staff had responsibility for patient observations whilst also being part of the response team or designated security person. Where patients were on five minute observations, some staff found difficulty maintaining these due to patient numbers and documentation to complete.
- The allocation of observations did not always occur in accordance with policy as there was not always evidence of input from the nurse in charge of the shift. Not all staff were familiar with the policy or had received training in undertaking observations effectively.

Summary of this inspection

- There was no evidence of staff undertaking regular checks of emergency equipment. The latest emergency simulations on the ward showed improvements were required. Staff did not have access to necessary medical supplies.
- There were two ligature risk assessments for the ward which differed to each other. It was unclear which staff were expected to follow. There were repeated incidents of patients breaking through doors and risks in the environment which had led to repeated incidents of self harm.

However:

- We observed that staff responded promptly to any incidents and patient feedback was that staff were good at helping to deal with these situations.
- Hospital management had already acknowledged shortfalls in adherence to patient observations and had started to address this by way of additional training.

Child and adolescent mental health wards

Safe

Are child and adolescent mental health wards safe?

Safe and clean environment

Prior to our inspection, we had been made aware of some concerns in relation to the safety of the environment. This included information about patients repeatedly damaging integral fittings and being able to access fixings in the environment to use to self harm. During our inspection visit, we identified environmental concerns which had the potential to expose patients to risk of harm.

During the three days of our inspection, there were four reported incidents of patients breaking through the air lock doors; of which there was a set at either end of the ward. Incident reports for the six months prior to our visit showed numerous instances of patients breaking through these doors. Extra magnets had been incorporated into one of the main doors to the ward to try to prevent it from being broken through. However, staff told us, and the recurring incidents evidenced, that this had not solved the problem. A number of incident reports also described patients breaking through the doors and using the broken magnets from the damaged doors to self harm. Staff told us patients kicking through the doors was a regular occurrence. One patient said the doors were damaged all the time and felt like staff had given up on trying to address this.

Further incidents related to patients repeatedly accessing items such as nails and screws from doors, chairs, fixtures and fittings. Patients told us they were able to access items in the environment to self harm. One parent was concerned that their child had told them they could extract materials from the furniture to self harm. Some work was evident on the ward, such as covered sockets, to try to reduce this. However, we saw that some areas of the ward were still a possible risk, for example an exposed screw outside of the seclusion room and furniture with rips in it. One incident in July 2017 involved a patient obtaining a product from the cleaner's trolley and ingesting a small amount. On one occasion during our inspection, we observed the cleaner mopping the communal bathroom with the trolley half in the open door and cleaning products on display in the half of the trolley outside of the room. There was a risk these items could have been taken and used by patients.

A member of the hospital security department had completed a ligature audit for the ward. The purpose of this was to identify and assess potential ligature anchor points in the environment. The audit available in the nurses' office had a completion date of 'March/April 2017'. It did not contain any actions for staff as to how to mitigate the identified risks. The hospital subsequently provided a further ligature audit dated 29 June 2017 completed by a different person. This document did include actions however it had some differing information to the audit we saw on site in relation to areas that had been risk assessed. As the audit on the ward was not the latest version and contained no actions, should staff have referred to this document, they may not have been familiar with all current risks how to manage these in a consistent way.

There were several ligature cutters on the ward including a set in the nurses office. The majority of staff knew where all were located. One staff member had to ask someone else as they had not worked on the ward for a while and could not recall where they all were. Two sets were kept in the ward managers office which was locked when not in use and staff did not have a key. There were plans to move these onto the ward to ensure they were accessible to all staff.

The hospital did not have robust procedures in order to respond to an emergency. The hospital's resuscitation policy stated emergency bags and resuscitation equipment should be checked on a weekly basis and after each use. We checked the emergency bag and saw the contents were in date. However, records showed that since and including 12 February 2017, there were only three documented checks of the emergency bag and defibrillator. A health and safety audit of the hospital completed in June 2017 said that staff on all wards completed regular checks of the ward's emergency equipment. The audit had failed to identify that the equipment was not being checked on Haven ward in accordance with hospital policy.

At the time of our visit the defibrillator was not present on the ward as it was undergoing some tests and new ones

were on order. A sign was up to inform staff where the nearest one was in the hospital. On our third day of inspection, we saw the new defibrillator on the ward and accessible to staff.

The resuscitation policy said simulation exercises should take place quarterly on each ward. We reviewed the latest records of these for Haven Ward which were dated November 2016 and 9 and 10 March 2017. The November 2016 simulation outcome was 'requires improvement'. The simulations from 9 and 10 March were rated as 'fail' and 'passed with improvement required', respectively. It was not clear whether, or how, all areas for improvement had been addressed since this time to prevent recurrences of the same issues. This meant there was a risk that should an emergency situation occur, patients may be at increased risk of harm if staff did not respond appropriately in such a situation.

Medical equipment was not readily available to all staff. The clinic room on Haven was located in the nurses station on the ward. There was also a physical health room situated off the ward. At night this could be unlocked by the nurse but supply cupboards were locked as the physical health team controlled access and they worked during the day. The nurse in charge of the ward was the only person who held the keys to the ward clinic room which also stocked medical supplies. This meant that other staff did not have ready access to necessary equipment, such as gloves and dressings should they require these quickly, for example to dress a wound where a patient may have self harmed. Staff told us this caused problems as it meant they had to rely on a single staff member, who may not always be available, in order to access supplies. This had the potential to cause delays to patients requiring medical care on the ward.

Safe staffing

The ward operated on a mix of substantive staff employed directly by the provider, bank staff, agency staff with set term contracts and ad-hoc agency staff used as and when required. The core staff group was made up of qualified nursing staff, senior mental health support workers and mental health support workers. Rotas showed a regular mix of these disciplines were rostered to work on each shift. In the day time, there was also a ward manager and a clinical team leader who worked five days a week on the ward.

At, and since, our last comprehensive inspection, the hospital had already identified a high use of agency staff. On-going recruitment was taking place to try to reduce the reliance on agency staff and this had gradually begun to improve with vacancies being recruited into. The interim manager provided us with details of agency usage on Haven ward for the previous three months and expected usage for the month the inspection took place. These were as follows:

Agency usage for April 2017 - 40%

Agency usage for May 2017 - 36%

Agency usage for June 2017 -Provider's expected forecast 38-40%

Agency usage for July 2017 - Provider's expected forecast 52%

The interim manager advised the higher forecast for July 2017 was due to patient observations increasing following the serious incident, and therefore the need for more staff to undertake these. Managers said the hospital tried to use familiar agency staff and it was rare to get staff who had not previously worked on the ward. Rotas had recently changed so there was a mix of regular staff on both day and night shifts. New agency staff undertook a period of induction designed to orient them to the ward and inform them of important information. This included health and safety considerations and the location of emergency equipment and information about ward security.

Patients said they knew the permanent staff members but were not always familiar with agency staff. Three told us agency staff did not always introduce themselves and that night time had a particularly high use of agency staff. Parents and carers told us they spoke to a number of different staff, some of who did not know information about their child

The ward manager for Haven was new in post. Prior to her arrival, the ward manager from the other childrens and adolescents ward in the hospital had temporarily been managing the ward. Both ward managers told us they felt staffing numbers were suitable and they could increase this according to need. A daily staffing tool setting out the levels within the hospital was circulated to ward managers to help identify where extra resources may be available if required. Most staff we spoke with said although core staffing levels looked suitable, this was not always the case

in practice. This was because if patients' needs changed, such as a requirement for increased observations; or an increase in incidents, this put pressure on staff having the time to meet these demands. It could lead to difficulty in getting cover and additional staff at short notice. Some said when all staff were allocated their set observations and tasks, this could leave only one staff member free to provide support to patients. However, another staff member said there were as many as two or three staff free and that patients always had the opportunity for one to one time.

We observed there to be many visible staff on the ward and saw that most of the time they were undertaking observations, engaged in necessary administrative duties or responding to incidents. There appeared to be little opportunity or evidence of dedicated one to one time with patients. However, our inspection took place following an incident which had led to a ward level increase on observation levels and therefore staff were primarily being utilised for that basis.

Most patients we spoke with felt current staffing levels were fine and said they had increased since the recent serious incident. However, one patient said despite this, they felt that there were not enough staff to support all the patients' needs.

Assessing and managing risk to patients and staff

Staff we spoke with said patient risks were always discussed within each handover and this was a detailed process and a main source of information. Senior staff told us they ensured temporary agency staff were made aware of risks with an emphasis on those at high risk.

During our inspection we observed handover between the day and night shift which was led by the senior nurse on shift and attended by staff on the oncoming night shift; although one staff member attended part way through. Handover information included each patient's observations levels and details of incidents that had taken place. Observations were allocated by a senior support worker for the first hour of the shift in which time a specific staff member allocated these for the remainder of the shift after handover.

The hospital operated what was called a shift code on night duty which consisted of two staff teams working alternate days. Where patients were newly admitted, their full history was only provided to the oncoming shift on the day of admission. There were differences in staff accounts as to how this information was communicated between shifts. Some staff said their shift code was updated by the nurse in charge in these situations; whereas others said they were expected to read the patient's records but there was not always time to do so. One staff member told us they did not look at patient's records. This meant staff may not be familiar with the risks and care needs of all patients who were in their care, and for whom they may have the responsibility to observe and engage with.

Staff used a risk assessment tool known as the short-term assessment of risk. Staff had completed these in the records that we looked at. Following assessments of their risks, each patient also had a 'staying safe' care plan to help inform what support they required to help manage their risks. We found that these care plans were not always comprehensive and did not always fully reflect patients' risks. For example, one patient's most recent staying safe care plan included several known areas of risk they presented with. The patient's daily progress notes included several instances of the person tying ligatures around the neck but this was not included as a known risk in their care plan. Another patient had numerous incidents documented of a repeated self harming behaviour but this behaviour was not documented in their care plan. The hospital had introduced care plans to identify what triggers and behaviours patients presented with and what interventions staff could employ to help them stay safe. However, these were variable with some not completed, some partially completed and some giving limited basic information.

Documentation about risks in some of the records was confusing and it was not immediately apparent what the current risks were. This was because some records contained several versions of a care plan for the same area yet these were titled differently and contained differing levels of information. We showed the ward manager an example who agreed it was confusing as to what plan staff would be required to follow. There was no evidence of one patient's risk assessments and associated care plans being reviewed since the beginning of May 2017 even though these should have been reviewed monthly at a minimum. Some documentation in the records we looked at were not signed to show who had been involved in compiling the information. Two patients' care plans included incorrect observation levels as these had increased but staff had not updated care plans to reflect this.

Child and adolescent mental health wards

Staff practice with regard to engagement and observation of patients was not consistent with hospital policy. The policy stated the nurse in charge had overall responsibility for allocation of staff to undertake observations. Managers said a senior support worker could complete the allocation sheet with input from the nurse. During our inspection in the daytime, we observed the nurse in charge and a support worker jointly discussing allocations and which staff to use. However, on the night shift, a support worker completed the allocations alone and without any input from the nurse in charge. Allocation sheets did not include the name of the staff member who had completed them, nor evidence of the nurse's input or oversight. Several sheets were missing for the previous days as staff did not routinely save these. Without these it would have been difficult to establish who had responsibility for a patient's observations at any given time. Such information may have been required in order to investigate complaints and incidents.

Staff told us, and records showed that staff were allocated to complete observations whilst also fulfilling other roles such as security lead and response team. Staff told us, if allocated to these roles, they would ask a colleague to cover observations for them if they were required to respond to an incident for example. However, there was no documented procedure to inform staff how to manage the role requirements should such an issue occur; and to help ensure patient safety was not compromised by the dual roles. Without clear guidance to help enable a consistent approach, or a measure that did not require staff to fulfill both roles, there was a risk that patients may not receive safe and appropriate care.

Patients' observation recording forms and progress notes showed the multi-disciplinary team had discussed and agreed observation levels and the rationale for these. The engagement and observation policy said where intermittent observations were less than 15 minutes in frequency; there should be a 'clearly defined local protocol' for these. At the time of our inspection, three patients were on five minute observations. Staff were aware of a protocol but were not able to explain the content and could not locate this. We later received a copy of the protocol from the quality manager. Two staff reported difficulties completing five minute observations within the given time; due in part to the number of patients on five minute checks they were responsible for and recent extra recording that had been introduced. This suggested that the resources for maintaining this had not been fully taken into consideration. Investigation of a recent complaint had identified an instance of several patients on five minute observations who were not observed at the required frequency.

Staff understanding of the engagement and observation policy varied. Some said the policy was regularly discussed and they had specific training in observations; whereas others recalled no training and were not familiar with the policy. Since the recent serious incident, contracted agency and permanent staff had completed a 'review of understanding' document' which was a requirement of the policy. At the time of our inspection, six agency and 19 out of 23 substantive staff had completed this but not all had received feedback. Whilst this demonstrated reinforcement of the policy to staff, this was reactive rather than proactive as the policy said these should be completed by every staff member prior to undertaking observations which was not the case in practice.

Patients had varying understanding of restrictions in place as part of their observations, such as supervised access to communal bathrooms and restricted access to their own bedrooms. Four patients knew what restrictions were in place and said this was based on their own individual risks and that staff explained why these were required. Two patients said they were not given explanations of their restrictions. One said they had been still been able to access their room despite it being restricted. We were aware that this same situation, of a patient accessing rooms that were restricted, had also recently occurred in relation to another patient and also a group of patients.

Patients said any aggression on the wards was primarily caused by incidents started by patients. They said staff intervened quickly and managed these situations. During our time on Haven ward, a number of incidents took place. We saw staff responded quickly and were able to help diffuse situations before they escalated. Where patients we spoke with had been restrained by staff, they told us this was to calm them down and they felt it was handled adequately. All except one said staff gave them an explanation and debrief after such incidents. Following the recent serious incident, patient's notes showed they had received a debrief with the clinical team leader and another

with the psychologist though the content of these was not documented. Where other more routine type incidents had occurred, there was not always evidence of debriefs taking place.

There was a safeguarding link person in post at the hospital who had oversight of safeguarding reports and was responsible for liaising with the external local authority where required. Seventy one percent of Cygnet staff were current with their safeguarding children training and 96% with safeguarding adults training. However, not all staff were fully familiar with how to identify and report safeguarding concerns where they arose, especially outside of core hours. The two ward managers we spoke with knew how to contact the local authority directly to report concerns if necessary. However, all other staff told us they would report it to a nurse in charge but did not describe being able to report safeguarding concerns directly to the local authority themselves.

We found not all incidents that met the criteria for safeguarding were triaged and referred as safeguarding matters. The daily notes of one patient documented a recent physical altercation with another patient. Staff had taken action at the time such as diffusing the situation, supporting the victim and increasing observations. However this had not been reported as an incident and was not referred to safeguarding. The ward manager confirmed this should have been logged as a safeguarding incident and assured us she would follow this up. We reviewed incident reports for the six months prior to our inspection and saw several incidents which described physical assaults between patients. These were not included within the records of safeguarding concerns the hospital provided to us. This showed that safeguarding procedures were not vigorous which potentially put patients at increased risk of exposure to harm.

One patient's records showed they had been involved in a recent situation, unrelated to the hospital, which staff had referred to safeguarding. There were certain restrictions in place to help safeguard the patient as a result of this. On review of the patient's care records, although the incident was recorded and discussed in multi-disciplinary meetings, there was no care plan to provide guidance on the actions required to help keep the patient safe. Managers told us they would expect such a plan to be in place. Without this information, there was a risk staff may not have been aware of what support the person required in relation to this matter. We brought this to the attention of senior staff. When we returned the next day, the safeguarding lead had compiled a detailed care plan to address this matter which was present in the patient's record.

Some patients at the service identified as a different gender but there was very little information present in their records about this or what support needs or preferences they may have in relation to this. There was a reported incident where one of the patients had raised concerns about staff attitude towards them regarding this matter. It said they felt staff were not receptive of their identity. Another patient told us about staff using terminology not in line with one of the patient's preferences which they felt was intentional. One parent said staff gave no consideration towards their child's gender identity needs and felt they did not see the importance of this to the patient. Four patients also made separate reference to other comments by staff they perceived to be judgemental, particularly when patients had self harmed. This was supported by comments from some parents who reiterated their children had told them this also. These findings suggested there was a lack of consideration towards patients individual needs which had led to a perception of discrimination in some cases.

Reporting incidents and learning from when things go wrong

Staff said they knew how to report incidents and gave consistent examples of types of incidents they reported. The hospital used an electronic incident reporting system which the manager reviewed regularly to determine any further action required. Non contracted agency staff did not have access to the reporting system but said they could relay information to a staff member who did have access.

We looked at incident reports for the ward over the previous six months. Although we saw staff had reported numerous incidents not all incidents were documented on the incident reporting system. For example, one patient's progress notes described a recent physical altercation between them and another patient. Staff had not reported this as an incident which was confirmed by our review of the incident data. During the first night of our visit, a potentially serious situation of an alleged overdose by a patient under constant staff observation occurred. This resulted in staff escorting the patient to the accident and emergency department. We read the patient's progress notes the next day which gave an account of what had happened and subsequent outcome of the hospital visit

and tests. These did not indicate that any harm had been caused. This had not been reported as an incident on the incident reporting system which meant the manager may not have been aware of this and may not undertake any further investigative review if this was deemed necessary. We told the ward manager about this to ensure it was appropriately logged and so they could review what further actions were required.

Four parents and carers told us staff did not always keep them updated about incidents. One said this was due to their child being over 16 and choosing not to share certain information. Where this was not the case, parents and carers cited certain incidents that had taken place that staff had either; not informed them about, not been aware of, or had told them about some time after the incident occurred. They attributed this in part to poor communication and differing staff who were not familiar with their child or events on the ward. However, two parents and carers said staff were good at keeping them updated about any incidents but felt this may be due to them calling the ward frequently. Another said they were not told about every incident but did not feel this was necessary and had no concerns with this.

There was evidence in the integrated governance framework of incident breakdowns and reviews of themes and trends. It was not apparent this was fed down to ward level staff. Five staff members told us they did not receive feedback from incidents they reported, even when some had specifically requested this via the reporting system. Most staff said feedback was only given in response to serious incidents, such as the recent one that had occurred. Staff debriefs following incidents was not consistent. Of the staff we spoke with, half said these took place and half said they did not regularly occur although they were aware these were supposed to happen. The ward manager said this was an area that could be improved and needed to be better evidenced.

We requested copies of recent staff meeting minutes and received minutes of a staff meeting dated 19 May 2017 with the names of seven staff members. The provider was not able to locate further minutes. The minutes did not include details of any discussion about incidents that had taken place. Our findings demonstrated that there were missed opportunities for incidents to be investigated. We also identified that necessary actions had not been taken because as the incident reporting process was not robust. Feedback to concerned parties, and other relevant people such as the staff team as a whole, was lacking or limited which prevented shared learning with an aim to reduce further recurrences.

Since the last comprehensive inspection in July 2016 we have received no new information that would cause us to re-inspect this key question.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that risk assessments and care plans accurately reflect each patient's known risks. There must be sufficient information present about risk warning signs, triggers and behaviours patients may present with; and what support and guidance they require to help manage these. Patients must be able to contribute and inform these assessments and plans.
- There must be effective processes in place to ensure all staff are aware of all patients current risks. There must be a system in place to ensure these are communicated to all relevant staff.
- The provider must ensure staff report incidents as required by their policy. These must be proportionately investigated and any feedback and learning shared appropriately.
- The provider must ensure that a debriefing is an integral part of post incident reviews.
- The provider must ensure all staff are fully aware of how to identify, and report, safeguarding matters. This must include how to report these via the hospitals internal systems and how to make referrals direct to the local authority where required.
- The provider must ensure that where safeguarding concerns are identified, there is sufficient and suitable information available about how to help keep individuals safe and how to manage associated risks.
- The provider must ensure that patient individuality is respected and staff do not discriminate against patients or show a lack of regard where they may have needs, or require support, with any protected characteristics.
- The provider must ensure the procedures for dealing with emergencies are safe. Staff must check emergency equipment at the required frequency and take necessary action where required.
- The provider must ensure that actions to make improvements, including those identified during emergency response simulations, are taken in a timely manner.
- The provider must ensure that all staff have access to necessary medical provisions.
- The provider must ensure that environmental risks in the premises are suitably risk assessed and that staff are clear about what they need to do to mitigate such risks. This includes the risk posed by repeated damage to the air lock doors and fixtures and fittings used to self harm.
- The provider must ensure there is a system of ensuring observations are undertaken to ensure the safety of patients. There must be clear processes and definitions as to each staff member's role during each shift. The provider must have assurance that staff have the necessary training and resources in accordance with the policy.
- The provider must ensure that records relating to patients care and treatment are current and regularly reviewed.

Action the provider SHOULD take to improve

- The provider should review the level of information included in debriefings so they can assure themselves these are meaningful and appropriate.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment was not provided in a safe way for people using the service. Risk assessments were not always reflective of patients known risks. There was limited information in care plans about patients' triggers and behaviours to help inform management of risk. Processes were not robust to ensure all staff were aware of patient risks; especially in circumstances where they were not familiar with the patients. Staff did not always identify and report incidents as required. There were risks relating to the procedures for responding to emergencies; specifically in relation to frequency of equipment checks, outcomes of simulations and staff access to medical supplies. The premises were not always safe to use for their intended purpose and used in a safe way. Known environmental risks had led to repeat incidents with little evidence of action to mitigate these. Regulation 12 (1) (2) (a) (b) (d) (f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

Systems and processes were not established and operated effectively to prevent abuse of people using the service.

Incidents, including physical assaults between patients, were not always identified and reported as safeguarding matters and in accordance with policy.

Not all staff were familiar with how to report safeguarding concerns, including directly to the local authority where required.

Where a safeguarding issue had been identified, there was a lack of information about what was required to keep the person safe.

There was a lack of regard in provision and support for people in relation to their gender identity. Some patients felt staff were judgmental and discriminatory.

Regulation 13 (1)(2)(3)(4)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** Systems to assess, monitor and mitigate risks to people using the service were not fully effective. The process for allocation of patient observations did not accord with policy and there was a lack of oversight to identify and address this. Records of patients care were not always accurate and complete. Staff did not keep all documentation relevant to patient's care. Some care records contained several versions of care plans for the same area with differing levels of information.

This section is primarily information for the provider

Requirement notices

There was no evidence of routine learning from incidents. Staff did not receive feedback from incidents and information was not shared and discussed as a way to improve the service.

Some people using the service, and their carers, said they received no feedback to incidents.

Debriefs following incidents did not always occur.

Regulation 17 (1) (2) (a) (b) (c) (e)