Cygnet Hospital Coventry

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 did not rate Cygnet Hospital Coventry at this inspection because this was an unannounced focused inspection to check specific concerns that patients and relatives had raised with the CQC.

Due to the concerns we found during this inspection, we used our powers under section 31 of the Health and Social Care Act 2008 to take immediate enforcement action and placed additional conditions on the provider's registration. Following work the provider did to provide assurances about the safety of the service, the conditions were reduced to those which were previously imposed after the comprehensive inspection in July and August 2019. The conditions we placed upon the provider's registration in 2019 required the provider to close one ward and cap admissions to another. Following this inspection in March 2020, the provider voluntarily closed another ward.

We inspected specific areas of the safe key question to look at areas of concern that patients and relatives had told us about. We did not inspect all areas or rate the key question of safe at this inspection. This is what we found:

- The service did not have enough nursing and medical staff who knew the patients well enough to keep patients safe from avoidable harm. Staff received basic training to keep patients safe from avoidable harm but not all staff implemented it well. Patients reported there were not enough staff to meet their needs. The hospital remained heavily reliant on bank and agency registered nurses
- Staff did not always assess and manage risks to patients and themselves well and did not follow best practice in anticipating, de-escalating and managing challenging behaviour.
- The service did not always manage patient safety incidents well.

However:

- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- 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. Apart from one significant incident, the provider had good arrangements in place to identify and deal with safeguarding.

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Background to Cygnet Hospital Coventry

Cygnet Hospital Coventry is part of the Cygnet Healthcare group. The group provides health care services nationally.

The hospital is purpose built, providing inpatient mental health care and treatment for women. It opened in April 2017. It has three wards; The Spires, Ariel and Middlemarch and a transitional living unit attached to one ward called St Mary's Court.

The Spires was previously called Dunsmore ward and changed its name after the last comprehensive inspection in July and August 2019. The ward has been closed to admissions since September 2019. The ward remains closed but, if open, could facilitate up to 16 beds and provide psychiatric intensive care.

Ariel has 16 beds and provides care and treatment specifically for women with a diagnosis of personality disorder. Ariel also provides care and treatment for women with a diagnosis of disordered eating and personality disorder. Admissions to Ariel were capped at 12 following the last comprehensive inspection in 2019. Since carrying out this inspection, the provider has temporarily closed Ariel. Patients from the ward were moved on to other services, in line with their clinical need and progress, or moved to Middlemarch to continue their treatment pathway.

Middlemarch has 16 beds and provides high dependency inpatient rehabilitation. St Mary's Court is attached to Middlemarch and has seven studio apartments providing transitional step-down support.

The last comprehensive inspection of this hospital took place in July and August 2019, when it was rated inadequate overall. The rating for that inspection was inadequate in safe, requires improvement in effective, inadequate in caring, requires improvement in responsive and inadequate in well led. We used our legal powers under the Health and Social Care Act and placed conditions on the provider's registration as a result of the concerns we found during that inspection.

An unannounced focused inspection was carried out in February 2020 following concerns raised by patients about how staff carried out night time observations. Observations were being completed effectively when we carried out that inspection. We did not rate the hospital at that inspection.

This inspection was unannounced, responsive and focussed, based on concerns we received from patients and families. They had told us there were not enough staff of the right skill level and experience to provide patients with the support they needed. Some told us they did not feel safe because staff did not always respond to them in the right way. They told us the number of patient incidents had increased and staff had not carried out a patient search in the right way.

We did not rate the hospital at this inspection. The rating from the last comprehensive inspection remains in place.

The hospital does not currently have a registered manager but is in the process of applying to CQC for a new manager to be registered.

Our inspection team

The team that inspected the service comprised one CQC inspection manager and four inspectors. This was an urgent, short notice inspection, which meant we were not able to include an expert by experience. An Expert by Experience is a person with lived experience or is the carer of a person with lived experience of using health and care services.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection because we had concerns about the care and treatment provided at Cygnet Hospital Coventry.

This was an urgent, unannounced focused inspection to look at concerns raised by patients. Concerns related to staffing levels, risk management and the way patient searches were carried out.

Hospital staff did not know we were coming. We carried out the inspection over one day.

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?

This was an urgent focused, responsive inspection so we looked at specific issues, not the five key questions.

Before the inspection visit, we reviewed information that we held about the location, including intelligence gathered during a CQC Mental Health Act Monitoring visit carried out several days before.

During the inspection visit, the inspection team:

- visited each ward to look at the quality of the ward environment and observed how staff were caring for patients
- spoke with the hospital manager and the clinical manager
- spoke with one other member of staff
- observed a clinical management meeting
- looked in detail at incident records, observation records, staff rotas, staff training information, complaints and safeguarding referrals
- looked at six individual patient risk assessments; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

This was an unannounced, focused short notice inspection. We did not speak with patients during the inspection. However, we spoke at length with eight patients a few days before the inspection when CQC carried out a Mental Health Act Monitoring visit to the hospital. The intelligence gathered during these interviews along with communications from patients and relatives led to CQC carrying out this inspection.

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 inspected specific areas of this key question. We did not inspect all areas or rate the key question of safe at this inspection. This is what we found:

- The service did not have enough nursing and medical staff who knew the patients well enough to keep patients safe from avoidable harm. Staff received basic training to keep patients safe from avoidable harm but not all staff implemented it well. Patients reported there were not enough staff to meet their needs. The hospital remained heavily reliant on bank and agency registered nurses
- Staff did not always assess and manage risks to patients and themselves well and did not follow best practice in anticipating, de-escalating and managing challenging behaviour. There were incidences where staff had not adhered to the provider's engagement and observation policy and incidences where staff had not followed individual patient care plans with respect to enhanced patient engagement and observation. Patients reported that staff did not appear sufficiently confident or skilled when patients exhibited heightened levels of distress or required support in the form of restraint.
- The service did not always manage patient safety incidents well. Staff did not adhere to the provider's search policy during one significant patient search event and staff had been slow to identify the incident may have brought about safeguarding concerns for a patient. The hospital admitted a patient without being assured the service could meet the patient's needs. The admission led to the ward becoming unsettled and experiencing an increase in incidents, including assaults on staff

However:

- The provider acted swiftly on our concerns about a patient who was not appropriately placed at the service and arranged a swift transfer to another hospital. They provided an updated patient search policy with additional training for staff and implemented additional patient engagement and observation training.
- Staff reported incidents and managers investigated them. The service made changes to improve practice. Patients' risk

Summary of this inspection

assessments were thorough and staff regularly updated them to reflect changes in patient risk. Apart from one significant incident, the provider had good arrangements in place to identify and deal with safeguarding.

Detailed findings from this inspection

Mental Health Act responsibilities

This was a focussed, responsive inspection to look at specific concerns that had been raised with us. We did not inspect how the provider carried out their responsibilities under the Mental Health Act 1983 at this inspection. However, CQC carried out a Mental Health Act Monitoring visit to the hospital during the same week as this inspection. We used the intelligence from that monitoring visit when carrying out this inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

This was a focussed, responsive inspection to look at specific concerns that had been raised with us. We did not inspect how the provider carried out their responsibilities under the Mental Capacity Act 2005 at this inspection.

Acute wards for adults of working age and psychiatric intensive care units

Safe

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

We carried out this inspection to look at specific concerns that patients and relatives had raised with us. We did not inspect the whole of this domain.

Safe staffing

The service did not have enough nursing and medical staff who knew the patients well enough to keep people safe from avoidable harm. The service did not have enough staff who had received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe.

- The service did not have enough nursing staff to manage the needs of patients. The hospital used a sliding scale of core staffing establishment, which was determined by the number of patients on each ward, not by the acuity of patient need. Additional healthcare support workers were allocated to each shift if individual patients were prescribed increased or enhanced observations to manage their risks. However, the wards had to "absorb" the first incidence of increased observation.
- Several patients and relatives told us there were not enough staff to support patients' needs. Patients and relatives told us the wards were often short staffed, patients were often distressed, and some patients felt unsafe. They told us they had to wait for staff to get them a drink and to use the toilet. Patients did not always have regular one to one sessions with their named nurse.
- Analysis of staffing rotas showed there were enough staff based on patient numbers and increased observation levels. However, there had been an increase in patient acuity levels following a recent patient's admission and the wards had quickly become less settled with higher levels of incidents.
- The service had high vacancy rates and difficulty recruiting permanent registered mental health nurses.
- There was a high level of bank an agency staff used to cover shifts, resulting in a risk that staff did not know patients well enough to meet their needs. Managers tried to ensure consistency by offering long term contracts to agency nurses, to provide familiarity for patients and other staff. However, only 25% of shifts were covered by permanent staff between 19-27 February and 24% between 28 February and 11 March 2020. When staff do not know patients well, patients can feel insecure and unsafe, which can lead to a rise in incidents.
- We found two shifts of the 36 we reviewed did not show clear evidence of a registered nurse being on duty. The provider challenged this noting that senior managers who were registered nurses provided cover for those shifts.
- The service had low and reducing rates of bank and agency support workers. Recruitment for support workers was not a problem at the hospital and there were no vacancies. However, a number of support workers placed restrictions on when they would work, so recruitment to increase staffing numbers was ongoing to ensure sufficient permanent support workers would be available for all shifts.
- Following this inspection, the provider voluntarily closed Ariel ward. This meant that across the hospital they should be able to provide enough registered nurses to cover all shifts.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well and did not always follow best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

- Staff used a recognised risk assessment tool. We looked at a small sample of six patient risk assessments. Each was effectively completed, thorough and considered all risks. Staff had regularly updated the assessments to reflect changes in patients' risks.
- However, the hospital admitted a patient without being assured the service could meet their needs. The admission led to the ward becoming unsettled and experiencing an increase in incidents, including assaults on staff. We looked at the pre-admission and admission paperwork relating this admission. The paperwork did not clearly indicate that the hospital could meet the specific needs of the patient and we were not assured that the provider was clear about their ability to meet the patient's needs before agreeing to the admission. We shared our concerns with the provider about the impact this admission had on other patients. The provider listened to our concerns and quickly transferred the patient to another hospital which was more able to meet their needs.

Management of patient risk

- Staff could observe patients in all areas. However, there were incidences where staff had not adhered to the provider's engagement and observation policy and incidences where staff had not followed individual patient care plans with respect to enhanced patient engagement and observation.
- We analysed patient observation and engagement records. We looked randomly at the observation records for three patients covering 12 days of observations in total. On the whole, staff carried out patients' observations in line with the prescribed individual care plan. However, we found three observations records where recording was unclear or had been missed, so it was not evident that the observations had taken place. We found no harm had occurred as a result of these missed observation recordings, however incorrectly recorded or missed observations can lead to patient harm. We told the provider we had concerns about the way observations were carried put and recorded.
- We were concerned to find there were no neurological observations recorded for a patient who frequently engaged in self-harming head banging behaviour. We would expect to see staff record specific neurological observations in such circumstances, to ascertain if the patient was in need of medical attention.
- We saw examples of staff recording one to one enhanced patient observations when they could not actually see the patient because the patient had chosen to hide themselves behind a mattress or under bedding. This meant staff could not effectively understand and respond to the patient's risk. Some patients had told us they felt staff lacked the knowledge and confidence to undertake observations and respond to incidents effectively.
- There was an ongoing training programme for staff to complete training in the prevention and management of violence aggression, including de-escalation techniques. Staff were trained but did not always demonstrate confidence in using their training to support patients and keep them safe. Leading up to this inspection several patients and relatives told us they were not confident in the ability of some staff to support patients who were exhibiting heightened levels of distress and agitation.
- Some patients had told us staff were not confident in using their skills to de-escalate situations and others did not respond appropriately when patients were exhibiting distressed behaviours such as harming themselves. We raised these concerns with the provider who assured us they were working to improve both the understanding and response of staff.
- Following this inspection, the provider quickly implemented a competency-based refresher training programme for all staff. Senior managers and experienced staff from other locations were temporarily located to the hospital to support staff with their learning. Managers implemented a "back to basics" approach to bring about improvement in the prevention and management of aggression on the wards.
- Staff did not always follow the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.
- One patient raised concerns about a recent search incident, so we looked in detail at the recording of the incident and spoke at length about it with the hospital managers. The search had not been carried out in line with the provider's search policy. Records showed omissions in how staff had documented the decision making and the procedure. The provider had already identified this and had begun an investigation in to the incident at the time of the inspection. Staff had acknowledged the patient's concerns and assured them they would be involved in the investigation and kept

informed. They apologised to the patient, acknowledging the emotional impact of the incident. The provider had updated and circulated the search policy to staff, providing additional training. They were keen to learn from the incident and not to repeat it.

- Managers and senior ward clinicians attended a daily risk meeting where they considered changes in patients' risks and jointly agreed updated management plans. We observed one of these meetings and found the purpose was clear and the process was effective. Decisions made in the meeting were recorded for future reference.

Safeguarding

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.

- Safeguarding procedures and recording was clear and effective except in one case we reviewed, where a clinical decision had raised safeguarding concerns for a patient. We were concerned about the incident because it indicated that safeguarding had not been considered as an issue when it should have been. After the event, the service had identified the issue and was investigating the incident at the time of the inspection. We told the provider we were concerned about how they had handled this incident and they informed us they were conducting a thorough investigation and would share the learning within the wider organisation.
- Staff received training in safeguarding adults and children, the level of training delivered was dependent upon the role and grade of staff. Managers kept records of staff training compliance. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff completed training about how to recognise and report abuse, and they knew how to apply it. They worked with the local authority to support patients through safeguarding procedures. Social work staff met regularly with local authority safeguarding professionals to review safeguarding concerns and enquiries. The local authority ordinarily delegated authority to the provider to carry out their own safeguarding enquiries. The local authority did not have any concerns about the provider's ability to identify and manage safeguarding concerns and enquiries. Staff knew how to make a safeguarding referral and who to inform if they had concerns.
- A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.
- Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

- Staff knew what incidents to report and how to report them. There was a clear process for reporting and investigating incidents. Investigation of incidents had improved since we carried out the last comprehensive inspection. Records showed that incidents reported matched those recorded in the patient records. There was a clear record of incidents, which mangers reviewed each week. However, managers told us that staff had recently complained they did not always get feedback about incident report investigations. In response to this, managers told us they planned to communicate more effectively with staff when sharing outcomes from incident investigations.
- We looked at incident recording and found there had been an increase in reporting. Staff had been required to respond to increased levels of incidents, including assaults on staff. There had been an increase in the number of patient assaults on staff and an increase in patients exhibiting distressed behaviours over the weeks leading up to this inspection.

Acute wards for adults of working age and psychiatric intensive care units

- The provider had implemented changes to observation and engagement records and procedures following incident reporting. A new observation and engagement policy had been introduced, for which staff were in the process of receiving training. Key changes included a reduction in the length of time staff spent on continuous observations and the inclusion of a “floating” support worker to relieve staff who were carrying out observations so they could have a break.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must undertake a review of all service users' observation records and ensure that the level of service user observations prescribed throughout a 24 hour period are individualised, detail specifically when levels of observations should reduce or increase and are based on individual risk assessments, including mitigation of any risks identified (Regulation 12 Safe Care and Treatment).
- The provider must ensure that staff undertaking observations do so in line with the provider's engagement and observation policy and protocol (Regulation 12 Safe Care and Treatment).
- The provider must ensure there is clear documentation to inform staff of the current observation level of all patients, this includes details of any changes to patients' observation levels, and risk information is clearly recorded and is easily accessible to relevant staff (Regulation 12 Safe Care and Treatment).
- The provider must review and have in place an adequate system and process(es) in place to investigate safeguarding incidents. In particular the registered provider must:

i. Undertake review of all safeguarding incidents between 1 January 2020 and 13 March 2020, in particular Patient A.

ii. Take steps to action any findings in a timely and appropriate manner.

iii. Provide an action plan/written report regarding the process (Regulation 12 Safe Care and Treatment).

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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