### Overview of the service:

Cygnet Hospital Harrow provides services to people detained under the Mental Health Act 1983 and to people who use the service informally. It is divided into Springs Unit, Springs Wing and Byron Ward. Springs Unit, a low secure rehabilitation service and Springs Wing, a step down facility with two interconnected units which offer care and treatment to male adult service users with an
Autistic spectrum disorder and mental health needs. Byron Ward offers in-service user assessment and treatment for adults with a wide range of psychological conditions which include an in-service user addiction treatment and recovery programme.
Summary of our findings
for the essential standards of quality

What we found overall

We found that Cygnet Hospital Harrow was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

- Outcome 4: Care and welfare of people who use services
- Outcome 9: Management of medicines
- Outcome 16: Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 13th December 2010, observed how people were being cared for, talked to people who use services, talked to staff, checked the provider’s records, and looked at records of people who use services.

What people told us

People told us that they are happy in the service. They said that they feel involved in their care and are aware of and attend reviews. They told us that they find the staff friendly, helpful and approachable and that they have regular contact with their consultant, key workers and other staff and know who to speak to about their care and choices and how to complain. They said that they make decisions about the activities in which they take part. They told us that they are aware of the medication they are taking and why they are taking it. They told us "I'm happy here"; and "my medication makes me feel better".
What we found about the standards we reviewed and how well Cygnet Hospital Harrow was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights
People experience safe quality care, treatment and support because Cygnet Hospital Harrow assesses the individual needs of people from the point at which they begin to use the service, taking account of information passed on from previous care providers. Cygnet Hospital Harrow reviews people’s needs regularly by speaking to the people and their representatives and also as a result of updated medical information.

People contribute to their care and are supported to make decisions to ensure that all of their needs are taken account of. People who use the service know the staff who look after them and are confident about talking to them about their individual needs.

- Overall, we found that Cygnet Hospital Harrow was meeting this essential standard.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way
People on the units we visited who were detained under the Mental Health Act 1983 were prescribed medicines that were duly authorised in line with the Mental Health Act 1983 Code of Practice.

There were discrepancies between the quantities of medicines that had been supplied to Springs Unit and the quantities of medicines that had been recorded as administered to people, therefore it was not possible to confirm that people received the medicines as they had been prescribed.

- Overall, we found that improvements are needed for this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care
The registered provider has appropriate monitoring processes in place to ensure that people who use the services at Cygnet Hospital Harrow experience effective, safe and appropriate care and support that meets their needs and protects their rights.

- Overall, we found that Cygnet Hospital Harrow was meeting this essential standard.

Action we have asked the service to take
We are taking compliance action against Cygnet Healthcare Ltd.
We have referred the concerns to the local safeguarding adults team. We will check to make sure that improvements have been made.
What we found
for each essential standard of quality
and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety.*
Outcome 4:  
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
• Experience effective, safe and appropriate care, treatment and support that meet their needs and protect their rights.

What we found

Our judgement

The provider is compliant with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

People using the service told us that they attend regular meetings accompanied by their representatives to review their care plan, that they knew the purpose of the meetings and received notice of when they are planned to take place. They also told us that they see their consultant weekly and discuss their medical care with him. They told us that they have regular meetings with their key worker and occupational therapist and are able to discuss their care, how they are feeling and choose activities that they wish to do. People we spoke to said that they usually attend meals in the restaurant but if they don't it is through their own choice. Some people told us that they sometimes choose to have breakfast in their own room. All the people we spoke to said that they find the staff friendly and approachable.

Other evidence

We received information which raised a concern about the following and updating of care plans and that people sometimes miss meals. We looked at the care plans for five people, three on Springs Wing and two on Springs Unit; we also spoke with the five people. Each care plan included an admissions checklist and information from the previous care providers about the person’s personal history, covering their medical, psychological, social, family, cultural, religious and educational backgrounds in detail. The initial assessment was centred on the person’s
individual needs, behaviours and interests and included assessments of risks and how these should be managed and reviewed. The care plans also included a continuous written record which recorded observations by staff on at least a daily basis and more often where concerns were identified about the person’s wellbeing or behaviour. A psychologist’s report, a medical report and an occupational therapist’s report were included in documents prepared for individual care plan review meetings, minutes of which showed that attendees included the people using the service, their representatives and/or family, the key worker and the occupational therapist. The care plans indicated that these meetings take place on a six monthly basis. The minutes demonstrated that all of the attendees are able to contribute to the review of the person’s care. The care plans also included two psychological self assessments completed by the people during 2010. We tracked the pathway of care for one person who told us that they had a particular care need which had been discussed with their key worker. The continuous written record showed where intervention was made through a 1:1 nursing arrangement in order to address that person’s specific needs. This was followed through into a nurse’s report prepared for a care plan review meeting where discussion with the person and their representatives and proposed actions were recorded. In addition, the minutes of the weekly multidisciplinary team meetings reflected discussion of the progress of those actions. This demonstrates that the registered provider recognised the changing needs of people who use the service and continuity of care was delivered through effective communication between those providing the care, the people using the service and their representatives.

The occupational therapist’s reports commented on activities the people do on a daily basis. These included a range of activities such as visits to the local shops, cinema, working in the garden and learning a musical instrument. Staff told us that activities are planned both for groups and to reflect individual preferences. On Springs Wing we saw individual timetables for people displayed in office and we observed a meeting taking place between the occupational therapist and three people who use the service. Some people from Springs Unit had just returned from a group shopping trip as we arrived. We saw that staff were friendly and approachable with people using the service and that those people were comfortable speaking to them.

Each of the care plans we looked at included evidence of regular medical testing and, where appropriate, recommendations to reduce the dosage of medication were made based on the results and the changes recorded as being made. These changes were confirmed in people’s prescription records. They also identified where issues linked to a with healthy lifestyle, such as diet and exercise were raised by staff with the people using the service and recorded recommendations made and progress against these recommendations. During our visit we saw that people keep supplies of food such as fruit and cereals in their rooms, and have kitchen facilities in which to prepare their own food if they choose to.

Our judgement
People experience safe quality care, treatment and support because Cygnet Hospital Harrow assesses the individual needs of people from the point at which they begin to use the service, taking account of information passed on from previous care providers. Cygnet Hospital Harrow reviews people’s needs regularly by speaking to the people and their representatives and also as a result of updated medical information.
People contribute to their care and are supported to make decisions to ensure that all of their needs are taken account of.
People who use the service know the staff who look after them and are confident about talking to them about their individual needs.
Outcome 9: Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are major concerns with outcome 9: Management of medicines</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
</tr>
<tr>
<td>They told us that they know which medicines they are taking and why they are taking them.</td>
</tr>
<tr>
<td>&quot;My medication makes me feel better&quot;.</td>
</tr>
<tr>
<td>Other evidence</td>
</tr>
<tr>
<td>We received information that suggested that people using the service were being given higher levels of a medication used for treating epilepsy, anxiety and panic disorders (clonazepam) than they were prescribed.</td>
</tr>
<tr>
<td>We visited two units at the service; Springs Wing and Springs Unit. On both units all people detained under the Mental Health Act 1983 for more than three months had either consented to their treatment or had their medicines authorised by a Second Opinion Appointed Doctor, in line with the Mental Health Act 1983 Code of Practice.</td>
</tr>
<tr>
<td>We looked at the drug charts and saw that the medicines listed matched those on the consent forms. However there were discrepancies between the quantities of medicines that had been supplied to Springs Unit over a period of six weeks and the quantities of medicines that had been recorded as administered to people during that time. We compared the amounts of 2mg clonazepam tablets ordered with those patients who were prescribed this dosage and also counted how many tablets were left. We identified that there were a large number of 2mg tablets unaccounted...</td>
</tr>
</tbody>
</table>
for. We also noticed that a greater number of smaller tablets of clonazepam were remaining than should have been, based on the prescription records for the period we looked at. There was no clear evidence of monitoring of these medicines by the provider through the auditing of orders, supplies and prescription records. We were therefore unable to determine if people were only being given the medicines that had been authorised and in the correct dosage. We could not confirm whether people were being given higher doses than they were prescribed as our observations and conversations with people only provided evidence of inconsistencies in the number of tablets being used, not what had happened to them.

We saw patients' allergy status and the reason for giving ‘as required’ medicines were clearly stated.

We saw the room where medicines were stored and where people went to have them administered. Nurses explained how they ordered stock medicines and how the pharmacist came once a week to look at the prescription charts. We looked at the prescriptions for antipsychotic medicines and saw that they were prescribed in line with professional guidance.

When someone was prescribed the medicine clozapine, the people received the appropriate tests to ensure that they receive the most benefit from the medicine with the least side effects.

There were policies in place for the management of medicines at the service. Staff stated that training in medication management is provided by an external company and there are also e-learning courses available.

**Our judgement**

Cygnet Hospital Harrow is not compliant with this outcome.

On Springs Unit the records of the orders and outstanding stock of 2 mg clonazepam tablets were not consistent with the numbers of patients prescribed these dosages.

During the period 01/11/2010 to 13/12/2010 there were orders for a total of 800 x 2mg tablets, with 180 tablets remaining. Prescriptions for the corresponding period totalled 126 tablets or a maximum of 231 tablets if 1mg doses were administered as half a 2mg tablet.
Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says
This is what people who use services should expect.

People who use services:
• Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is compliant with outcome 16: Assessing and monitoring the quality of service provision</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
</tr>
</tbody>
</table>
People told us that they know who to speak to about their care and how to complain if they are not happy with the quality of the care.

Other evidence
We received information suggesting that staff concerns about the level of care provided were not dealt with properly by the registered provider. When we visited the registered manager told us that staff know that they can speak to him at any time if they have concerns. The registered provider interviewed two members of staff earlier this year as part of the quality assurance process. The staff members both said that standards of care were good but that if they needed to make a complaint or raise a concern they knew how to do so. We looked at the registered provider’s ‘whistleblowing’ policy which gives staff details of the procedure for raising complaints and offers them the opportunity to contact senior managers and directors if they prefer not to speak to their line managers about any concerns they have.

The information we received also suggested that care is not properly monitored. The registered manager told us that the therapy services manager conducts patients’ services questionnaires. We looked at audits of patient satisfaction questionnaires for the period July – September 2010. Patients rated their experiences of: admission, accommodation, medical care, nursing care,
housekeeping, catering, therapy, and accounting. The audit identified three areas in which improvement was needed. Recommendations to address these issues and improve the experience of people who use the service were included in the audit, along with an update of action already taken when the audit was published. The report of the registered provider’s statutory unannounced visit (dated September 2010) included interviews with three people using the service and stated that overall each of the people were satisfied with their experience at the hospital. We also looked at three further monitoring audits which the provider conducts with people who use the service at three monthly intervals. These audits were used to track and monitor patient experience of mental health services in a secure setting and identify how much progress patients were making and if there was a need to adjust their treatment.

We looked at five care plans, three on Springs Wing and two on Springs Unit. Each included a continuous written record which recorded observations by staff on at least a daily basis and more often where concerns were identified about the person’s wellbeing or behaviour. Whilst we were on Springs Wing we saw a member of staff conducting observations of people using the service. There were copies of clinical testing results within the care plans which were used to review medication given to people using the service. There were also records of regular risk assessments of planned activities. We looked at minutes of weekly multidisciplinary team meetings which were attended by all staff involved in each person’s care. We saw that the information from the observations clinical testing and risk assessments was used alongside the person’s history to review the care of each of the people using the service in these meetings to ensure that changes to the plan of care of people using the service could be made if the information gathered identified any risk to the patient through the care and support that was provided. .

The minutes of individual care plan review meetings showed that attendees included the people using the service, their representatives and/or family, the key worker and the occupational therapist. The care plans indicated that these meetings take place on a six monthly basis. The minutes demonstrated that the people using the service and their representatives are able to feed back on the quality and safety of the care, the treatment and support the service provides and the outcomes achieved.

Our judgement
The registered provider monitors the quality of service that people receive and identifies and monitors risk to people who use the service. It takes account of comments from people who use the service and their representatives, as well as people who work there.
Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment or medical treatment of people detained under the Mental Health Act 1983.</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On Springs Unit the records of the orders and outstanding stock of 2 mg clonazepam tablets were not consistent with the numbers of patients prescribed these dosages.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the period 01/11/2010 to 13/12/2010 there were orders for a total of 800 x 2mg tablets, with 180 tablets remaining. Prescriptions for the corresponding period totalled 126 tablets or a maximum of 231 tablets if 1mg doses were administered as half a 2mg tablet.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider’s report should be sent to us by 14th January 2011.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions**: These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions**: These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action**: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
Information for the reader

<table>
<thead>
<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>Audience</td>
<td>The general public</td>
</tr>
<tr>
<td>Further copies from</td>
<td>03000 616161 / <a href="http://www.cqc.org.uk">www.cqc.org.uk</a></td>
</tr>
<tr>
<td>Copyright</td>
<td>Copyright © (2010) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.</td>
</tr>
</tbody>
</table>

Care Quality Commission

<table>
<thead>
<tr>
<th>Website</th>
<th><a href="http://www.cqc.org.uk">www.cqc.org.uk</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>03000 616161</td>
</tr>
<tr>
<td>Email address</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
</tr>
<tr>
<td>Postal address</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td></td>
<td>Citygate</td>
</tr>
<tr>
<td></td>
<td>Gallowgate</td>
</tr>
<tr>
<td></td>
<td>Newcastle upon Tyne</td>
</tr>
<tr>
<td></td>
<td>NE1 4PA</td>
</tr>
</tbody>
</table>