## 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 licensed to provide the regulated services for people with mental health needs, learning disabilities and problems with substance misuse, rehabilitation services, and residential substance misuse treatment and/or rehabilitation service.

<table>
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<tr>
<th>Region:</th>
<th>London</th>
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| Location address: | London Road  
Harrow-on-the-Hill  
Middlesex  
HA1 3JL |
| Type of service: | Hospital services for people with mental health needs, learning disabilities and problems with substance misuse  
Rehabilitation services  
Residential substance misuse treatment and/or rehabilitation service |
| Date of Publication: | December 2011 |
| activities assessment or medical treatment for persons detained under the Mental Health Act 1983, treatment of disorder or injury and diagnostic and screening procedures. Cygnet Hospital Harrow is part of Cygnet Health Care Limited. |
Our current overall judgement

Cygnet Hospital Harrow was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

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

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider.

What people told us

Patients told us that they felt safe in the hospital. They felt that their views were taken into account and respected and their dignity upheld. They told us that staff were approachable and listened to them.

Where patients had experienced restraint they felt that it was carried out in an appropriate way and for the right reasons.

Patients told us that they understood why their medicines had been prescribed.

Everyone we spoke with said that they were happy with the care they had received.

What we found about the standards we reviewed and how well Cygnet Hospital Harrow was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Patients had received regular opportunities to express their views on the service and had been involved where possible in decision-making about their treatment and support. Staff treated patients with respect for their dignity.

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

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights
Patients received safe care which was appropriate to their needs through a robust process of assessment and review from the time they were admitted to the service and throughout their stay.

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

**Outcome 07: People should be protected from abuse and staff should respect their human rights**

Patients were being looked after by staff who had been appropriately trained to deal with all of their individual needs. Whilst those needs had been identified in patients' records, identification of suitable types of restraint and associated assessments of risk were not in place. This could mean that staff who were not familiar with specific patients would not have all of the information necessary to ensure that the use of restraint was appropriate to an individual.

Overall we found that the provider was meeting this essential standard but to maintain this we have suggested improvements.

**Outcome 09: People should be given the medicines they need when they need them, and in a safe way**

The provider had systems in place which were followed by staff to ensure that people received their medication in a timely, safe and appropriate manner.

Overall, we found that Cygnet Hospital Harrow was meeting 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**

Patients benefitted from an appropriate monitoring system which was used to identify where improvements were necessary. Action had been taken in a timely manner to make changes to people's treatment as a result of the outcomes of the monitoring.

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

**Actions we have asked the service to take**

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

**Other information**
Please see previous reports for more information about previous reviews.
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*
What the outcome says
This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement
The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke with patients on two wards. They told us that they have the opportunity to attend community meetings on their wards on a daily basis and that they are able to express their views at these meetings on their care and the service itself.

Patients told us that they were able to discuss their care with staff and that they were listened to. Where patients were detained under the Mental Health Act 1983 they said that they felt happy that their views about the service and their treatment were welcomed by staff. Everyone we spoke with told us that staff treated them well and respected their dignity. We observed a number of interactions between patients and staff and found each of those to be polite, friendly and respectful.

Other evidence
The manager confirmed that short community meetings take place every morning and that patients are encouraged to attend. In addition, 'service user champions' attend a monthly meeting of a forum in which patients' views can be represented and explored in more depth. This group reports into the monthly heads of department meeting which is led by the registered manager.

Our judgement
Patients had received regular opportunities to express their views on the service and had been involved where possible in decision-making about their treatment and support. Staff treated patients with respect for their dignity.

Overall, we found that Cygnet Hospital Harrow was meeting this essential standard.
Outcome 04:
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 meets their needs and protects their rights.

What we found

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<th>Our judgement</th>
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<tr>
<td>The provider is compliant with Outcome 04: Care and welfare of people who use services</td>
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<th>Our findings</th>
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| **What people who use the service experienced and told us**
Patients we spoke with on described the activities in which they participated as part of a weekly timetable. They said that they could exercise choice about these activities.

Patients also told us that each person had an appointed senior nurse to whom they could go to with concerns at any time. They said that this member of staff would always try to deal with their concerns and if they were unable would escalate them to the most appropriate member of staff.

**Other evidence**
Staff told us that patients’ needs were assessed by the ward doctor and a clinician prior to admission. All admissions were planned. When new patients came on to the ward they were risk assessed and a more detailed assessment and a management plan were completed. Where possible this was done with the patient. Patients were also given an orientation to ensure they became familiar with all aspects of the service. All patients were monitored on a one-to-one basis for the first 24 hours of their stay and saw the consultant within 48 hours of admission. The appropriate procedures relating to mental health legislation were also completed at this stage to ensure that patients received the appropriate treatment.

We looked at four sets of patient records in which we found all aspects of the admissions procedures which had been described by the manager and ward staff. All aspects of patients’ medical and personal needs were regularly reviewed and updated following decisions by health care professionals.
We saw patients attending group therapy sessions which corresponded with individual timetables.

**Our judgement**
Patients received safe care which was appropriate to their needs through a robust process of assessment and review from the time they were admitted to the service and throughout their stay.

Overall, we found that Cygnet Hospital Harrow was meeting this essential standard.
What the outcome says
This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

<table>
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<tr>
<th>Our judgement</th>
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<td>There are minor concerns with Outcome 07: Safeguarding people who use services from abuse</td>
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<th>Our findings</th>
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<tr>
<td>What people who use the service experienced and told us</td>
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<tr>
<td>One person we spoke with had been restrained for their own safety the previous day. They told us &quot;I'm in total agreement with the use of restraint as I was very upset and it was the only thing they could do&quot;. Each of the patients we spoke with told us they felt safe at the hospital.</td>
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<tr>
<td>Other evidence</td>
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<tr>
<td>The manager told us that specific intervention plans were completed for each patient on the ward. We saw evidence in the nursing care plan that identification of the risk of a patient assaulting others had been identified; however the specific types of intervention suitable for use with each patient was not clearly identified. In addition, a risk assessment of the use of restraint or particular behaviour management had not been completed.</td>
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<td>Where restraint had been used this was recorded in an incident form. In addition, a review of the event, from start to finish was completed, including an assessment of any injury through completion of a body map.</td>
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<td>The manager also told us that staff had received a range of training in identifying reasons for and types of violence, types of de-escalation and types of restraint. Staff were also trained in personal safety breakaway training. We saw training records which demonstrated where staff on all units had either completed update training or were booked onto sessions in the near future.</td>
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**Our judgement**

Patients were being looked after by staff who had been appropriately trained to deal with all of their individual needs. Whilst those needs had been identified in patients' records, identification of suitable types of restraint and associated assessments of risk were not in place. This could mean that staff who were not familiar with specific patients would not have all of the information necessary to ensure that the use of restraint was appropriate to an individual.

Overall we found that the provider was meeting this essential standard but to maintain this we have suggested improvements.
Outcome 09: 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

Our judgement
The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We spoke with three patients on Springs Unit who all told us that they knew what medicines they were taking and what they were used for. They met weekly with their consultant and could talk to him about their treatment.

Other evidence
We visited Springs Unit where we had previously found concerns with the system used to account for medication held in stock. In response to our report the provider had told us that they had put more robust measures in place. We checked those procedures and saw they had been adopted within the medication policies and procedures on the unit.

All of the 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.

The medicines listed on the prescription charts we looked at matched those on the consent forms; therefore people were receiving the appropriate medicines. The person's allergy status and the reason for giving 'as required' medicines were clearly stated both on the prescription chart and within the person's care plan to ensure most effective use of these medicines.

We saw the room where medicines were stored and where people went to have them
administered. Systems were in place to ensure that medicines could be accounted for and records of medication were regularly audited to ensure that the controls in place were effective.

We found that medicines were stored securely, the temperature of the storage was recorded and action taken if this was incorrect. Nurses explained how they ordered stock medicines and how they received weekly pharmaceutical advice. The manager also told us that if a medicine is out of stock with the regular pharmacist there are alternative arrangements in place to ensure that people receive their medication regularly.

Where people were prescribed medicines which were required to be regularly monitored, this had been carried out to ensure they received the most benefit with minimal side effects.

We saw training records confirming that staff on all units had received regular updates to medication training.

**Our judgement**
The provider had systems in place which were followed by staff to ensure that people received their medication in a timely, safe and appropriate manner.

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

Our judgement
The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
All of the patients we spoke with told us that their views and feedback on the service were sought regularly through community meetings.

Other evidence
The manager told us that auditing of records was conducted under the service's quality improvement plan. Results were fed into and monitored by Cygnet Health Care Limited's clinical governance department. We saw minutes of the most recent of these meetings showing discussion of audit findings. Patients' views were sought through regular meetings, a service user champion on each ward and a quarterly questionnaire conducted by the provider. Relatives and carer's views were also sought approximately on a quarterly basis. Recommendations for action were identified on the basis of these exercises and recorded as followed up by the appropriate manager.

The patient records we looked at had been reviewed on a regular basis according to need or direction from the ward doctor or the consultant. This ensured that patients' treatment was up to date and reflected timely decision-making by the appropriate professionals.

Our judgement
Patients benefitted from an appropriate monitoring system which was used to identify where improvements were necessary. Action had been taken in a timely manner to make changes to people's treatment as a result of the outcomes of the monitoring.
Overall, we found that Cygnet Hospital Harrow was meeting this essential standard.
**Improvement actions**

The table below shows where improvements should be made so that the service provider *maintains* compliance with the essential standards of quality and safety.

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<th>Regulated activity</th>
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<th>Outcome</th>
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<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 07: Safeguarding people who use services from abuse</td>
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**Why we have concerns:**
Patients were being looked after by staff who had been appropriately trained to deal with all of their individual needs. Whilst those needs had been identified in patients' records, identification of suitable types of restraint and associated assessments of risk were not in place. This could mean that staff who were not familiar with specific patients would not have all of the information necessary to ensure that the use of restraint was appropriate to an individual.

Overall we found that the provider was meeting this essential standard but to maintain this we have suggested improvements.

| Diagnostic and screening procedures                                                | Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010          | Outcome 07: Safeguarding people who use services from abuse              |

**Why we have concerns:**
Patients were being looked after by staff who had been appropriately trained to deal with all of their individual needs. Whilst those needs had been identified in patients' records, identification of suitable types of restraint and associated assessments of risk were not in place. This could mean that staff who were not familiar with specific patients would not have all of the information necessary to ensure that the use of restraint was appropriate to an individual.

Overall we found that the provider was meeting this
<table>
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<tr>
<th>Treatment of disease, disorder or injury</th>
<th>Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010</th>
<th>Outcome 07: Safeguarding people who use services from abuse</th>
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**Why we have concerns:**

Patients were being looked after by staff who had been appropriately trained to deal with all of their individual needs. Whilst those needs had been identified in patients’ records, identification of suitable types of restraint and associated assessments of risk were not in place. This could mean that staff who were not familiar with specific patients would not have all of the information necessary to ensure that the use of restraint was appropriate to an individual.

Overall we found that the provider was meeting this essential standard but to maintain this we have suggested improvements.

The provider must send CQC a report about how they are going to maintain 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 within 14 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement 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 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>
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<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
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<tr>
<td>Author</td>
<td>Care Quality Commission</td>
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<td>Audience</td>
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### Care Quality Commission

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