Unannounced Inspection Report: Independent Healthcare

Service: Cygnet Wallace Hospital, Dundee
Service Provider: Cygnet (OE) Limited

18 August 2020
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1 Progress since our last inspection

What the provider had done to meet the requirement we made at our last inspection on 25-26 June 2019

Requirement
The provider must ensure that each patient’s physical healthcare needs are fully met. To ensure this requirement is complied with, the service must ensure that each patient has access to a doctor who has experience in treating patients with a learning disability or learning difficulty.

Action taken
The local health centre staff confirmed changes had been implemented in clinical care including regular liaison with the local health centre. The provider has also contracted a specialised doctor to carry out an annual physical health check for each patient. This requirement is met.

What the service had done to meet the recommendations we made at our last inspection on 25-26 June 2019

Recommendation
The service should review patient care records and see how they can be adapted to enhance and clarify the care planning process.

Action taken
The service has moved from paper patient care records to electronic care records. This has resulted in a clearer record of assessment, planning and implementation of care plans. This recommendation is met.

Recommendation
The service should carry out pre-employment checks in line with current legislation and best practice guidance.

Action taken
The service is now carrying out all pre-employment checks in line with Scottish Government guidance. This recommendation is met.
**Recommendation**

*The service should satisfy itself that appropriate health checks have been carried out for staff.*

**Action taken**

All new employees have appropriate health checks. **This recommendation is met.**

**Recommendation**

*The service should develop and implement a quality improvement plan.*

**Action taken**

The service has developed a local overarching action plan as its continuous quality improvement plan. **This recommendation is met.**
2  A summary of our inspection

The focus of our inspections is to ensure each service is person-centred, safe and well led. Therefore, we only evaluate the service against three key quality indicators which apply across all services. However, depending on the scope and nature of the service, we may look at additional quality indicators.

About our inspection

We carried out an unannounced inspection to Cygnet Wallace Hospital on Tuesday 18 August 2020. We spoke with a number of staff and patients during the inspection.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For Cygnet Wallace Hospital, the following grades have been applied to the key quality indicators inspected.

<table>
<thead>
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<th>Key quality indicators inspected</th>
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<tr>
<td><strong>Domain 5 – Delivery of safe, effective, compassionate and person-centred care</strong></td>
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<td><strong>Quality indicator</strong></td>
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<td>5.1 - Safe delivery of care</td>
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| **Domain 9 – Quality improvement-focused leadership** |
| 9.4 - Leadership of improvement and change | The service had an enthusiastic and motivated management team. A clear and comprehensive continuous quality improvement plan was in place to improve the quality of care. An evaluation system should be developed which should include staff views. | ✓ Satisfactory |
The following additional quality indicators were inspected against during this inspection.

### Additional quality indicators inspected (ungraded)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Quality indicator</th>
<th>Summary findings</th>
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<tbody>
<tr>
<td>Domain 5 – Delivery of safe, effective, compassionate and person-centred care</td>
<td>5.2 - Assessment and management of people experiencing care</td>
<td>Comprehensive clinical information on assessment, planning and current care needs was accessible to the multidisciplinary team. However, where staff were not confident in using the electronic system, there was a potential for these records not to be fully completed. The senior management team was already aware and was starting to address this.</td>
</tr>
<tr>
<td>Domain 7 – Workforce management and support</td>
<td>7.1 - Staff recruitment, training and development</td>
<td>The service follows the Scottish Government’s best practice guidelines on safer recruitment. Although agency staff supplied to the service had completed all the agency’s mandatory training, there was no record of a specific induction period for the agency staff into the service.</td>
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Grades may change after this inspection due to other regulatory activity. For example, if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

More information about grading can be found on our website at: [http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx](http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx)

### What action we expect Cygnet (OE) Limited to take after our inspection

This inspection resulted three requirements and four recommendations. Requirements are linked to compliance with the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, or a condition of registration. See Appendix 1 for a full list of the requirements and recommendations.
An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/find_a_provider_or_service.aspx

Cygnet (OE) Limited, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Cygnet Wallace Hospital for their assistance during the inspection.
3 What we found during our inspection

Service delivery

This section is where we report on how safe the service is.

Domain 5 – Delivery of safe, effective, compassionate and person-centred care

High performing healthcare organisations are focused on safety and learning to take forward improvements, and put in place appropriate controls to manage risks. They provide care that is respectful and responsive to people’s individual needs, preferences and values delivered through appropriate clinical and operational planning, processes and procedures.

Our findings

Quality indicator 5.1 - Safe delivery of care

While we saw good systems in place for managing COVID-19 risks, the infection prevention and control policy needs to be updated to reflect Scottish guidance and good practice. Agency nurses must receive appropriate training in COVID-19 risks, and alcohol-based hand rub must be available for use at the point of care.

At the time of the inspection, the operations director and a deputy operations director were responsible for overseeing the day-to-day running of the service. This included making sure the service’s policies and procedures were being implemented.

We reviewed the systems in place to prevent and control infection in the service. We saw that the service’s system for recording and reviewing ongoing risks now included COVID-19. A COVID-19 environmental risk assessment had been carried out and a new COVID-19 policy had been introduced. The risk assessment and policy identified the relevant risks in the service and provided clear guidance for staff on what they should do to control the transmission of COVID-19. These control measures included:

- increased cleaning of the environment, patient equipment and high touch areas such as door handles
- restricted access to the inpatient area
- an improved sign-in process that included recording temperatures and performing hand hygiene before entry and exit, and
- making sure staff wore fluid-resistant face masks whilst in the building.
The care environment and patient equipment was clean and well maintained. We saw staff wearing face masks, practicing hand hygiene and using the new sign-in process. We also saw that linen was being managed in line with national guidance, and waste was being appropriately disposed of and stored.

Information about COVID-19 risks, symptoms and control measures was displayed throughout the service. Different types of information was displayed in the ward area, in a way that patients would understand.

Staff had recently completed online mandatory infection prevention and control training and received additional training in COVID-19 control measures. We saw evidence of this in the service’s training compliance report. This showed a high uptake for permanent and bank staff.

Individual staff risk assessments had been carried out to make sure that each staff member’s personal circumstances had been considered in relation to COVID-19 risks. These had been carried out confidentially by each staff member’s line manager and the outcome of each was held securely in each staff member’s file.

**What needs to improve**

Although wall-mounted alcohol-based hand rub dispensers were available throughout the service, we found they were all empty. We were told this was due to supplies being consistently unavailable during the COVID-19 pandemic. To try and address this, portable alcohol-based hand rub dispensers had been provided. In the ward area, these portable dispensers were kept in staff areas due to the risk of patients ingesting the contents. This meant that staff needed to access a staff area to use the dispenser. Alcohol-based hand rub must be available for use at the point of care. For example, staff could carry their own personal alcohol-based hand rub dispensers (requirement 1).

While there was clear evidence that permanent and bank staff had received appropriate additional training about COVID-19 risks, similar evidence was not available for the four agency nurses recently appointed (requirement 2).

The service’s infection prevention and control policy was a corporate policy and was not in line with Scottish guidance and best practice (requirement 3).

The service had provided infrared thermometers at the main entrance to the building and ward. All staff and essential visitors were asked to use the thermometer to take their temperature and record the reading in a sign-in book. We tested the thermometers on multiple people and found both devices gave inconsistent readings. We discussed alternative approaches to managing access to the ward and main building during the pandemic with the operations
director. For example, purchasing more reliable thermometers or keeping a record of all visitors’ contact details (recommendation a).

**Requirement 1 – Timescale: immediate**
- The provider must ensure that staff are able to carry out hand hygiene at the point of care.

**Requirement 2 – Timescale: immediate**
- The provider must ensure that all agency staff receive appropriate education and training in COVID-19 risks and the necessary control measures.

**Requirement 3 – Timescale: immediate**
- The provider must ensure its infection prevention and control policy is in line with Scottish guidance, in particular Healthcare Improvement Scotland’s *Healthcare Associated Infection (HAI) Standards* (2015) and Health Protection Scotland’s *National Infection Prevention and Control Manual*.

**Recommendation a**
- The service should ensure that any system used to manage access to the building and ward during the pandemic is reliable and effective.

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**Our findings**

**Quality indicator 5.2 - Assessment and management of people experiencing care**

Comprehensive clinical information on assessment, planning and current care needs was accessible to the multidisciplinary team. However, where staff were not confident in using the electronic system, there was a potential for these records not to be fully completed. The senior management team was already aware and was starting to address this.

An electronic system of recording clinical information including care plans, risk assessments and patient reviews had been introduced in early 2020.

We saw that all members of the multidisciplinary team were able to contribute to the electronic patient care records. This helped to provide comprehensive information on assessment and planning, current levels of support required and outcomes of regular reviews.
The monitoring of patients’ health was overseen by the multidisciplinary team. This included specialist consultant input with two consultant psychiatrists employed by the service. They were available during core hours, and there was also a 24-hour on-call service. Staff told us they valued the continuity of consultant cover. Work had been carried out to improve compliance with the requirements of certain legal documentation, and to make sure medication and treatment plan monitoring was up to date and met the needs of patients.

This included:

- reviewing the need for detention under the Mental Health (Care and Treatment) (Scotland) Act 2003
- completion of relevant legal consent to treatment documentation and treatment plans for patients under the Mental Health (Care and Treatment) (Scotland) Act 2003, including for people who are unable to consent to treatment
- reviewing and updating Adults with Incapacity Section 47 forms for consent to treatment, and
- ensuring anti-psychotic monitoring had been completed on an annual basis and was clearly documented.

Annual health reviews had been carried out for all patients by a doctor with experience of assessing health needs of patients with a learning disability or learning difficulty. The provider had contracted additional medical hours to ensure these health checks had taken place.

Multidisciplinary reviews for individual patients took place every 4 weeks. An ‘easy read’ review meeting preparation form was available, and patients were supported to complete these through discussion with staff. These forms were then shared with the multidisciplinary team and identified particular discussion topics between staff and the patient during their review. Desired outcomes were clearly documented with agreed timescales. External healthcare professionals involved in a patient’s care were sent a summary if they were unable to attend.

The service had identified that communication with GP services was an area which could be improved. Meetings were held between the consultants, GPs and the practice manager to identify action that could be taken to improve communication. As a result of this, information about patients’ health needs was now formally shared with the patient’s GP.
We reviewed four patient care records and saw these were comprehensive and outcomes focused. The service was adhering to the current restrictions on allowing visitors. We saw examples in patient care records of discussion with patients and their families on how to address this for each individual, such as organising supervised outdoor visits.

Handover took place at the start of each shift. A handover book was also used as an additional means of identifying key issues and sharing information. A ‘flash’ meeting was also held every morning to look at immediate concerns or needs for individual patients.

What needs to improve
We were told that regular permanent and bank staff were trained in using the new electronic clinical information system. However, when agency staff were on shift they were not always familiar with how to use the system. There was a risk that this could lead to delays in signing off changes or recording relevant care or clinical information about patients. The senior management team acknowledged that all staff required to input into patient care records, including agency staff (recommendation b).

□ No requirements.

Recommendation b
□ The service should ensure that all staff, including agency staff, have access to, and can demonstrate competence in, use of the electronic clinical information system.

Domain 7 – Workforce management and support
High performing healthcare organisations have a proactive approach to workforce planning and management, and value their people supporting them to deliver safe and high quality care.

Our findings
Quality indicator 7.1 - Staff recruitment, training and development
The service follows the Scottish Government’s best practice guidelines on safer recruitment. Although agency staff supplied to the service had completed all the agency’s mandatory training, there was no record of a specific induction period for the agency staff into the service.
We reviewed four staff files and saw that appropriate references and Protecting Vulnerable Groups (PVG) checks were in place. Staff qualification certificates were held on file, and job descriptions, interview records and contracts were also available. We saw that the occupational health status of all staff was checked and recorded.

Annual professional registration and revalidation status checks were carried out for all clinical staff. Revalidation is where clinical staff are required to send evidence of their competency, training and feedback from patients and peers to their professional body, such as the Nursing and Midwifery Council, every 3 years.

We spoke with one member of staff who had recently been employed. They told us they had an “outstanding” induction period and felt very supported during their initial phase of employment.

**What needs to improve**
At the time of our inspection, staff told us there were a number of vacancies for trained nursing staff. In order to make up this shortfall, the service was using agency nurses. An agreement had been reached with the agency that the service would use the same staff to help promote consistency of care.

We saw that the agency nurses had completed all mandatory training required by the agency. However, although they were already in post, they had not yet completed the mandatory e-learning courses specific to the service. We also found there was no record of induction for the agency staff (recommendation c).

- No requirements.

**Recommendation c**
- The service should ensure that all agency staff have a period of induction in the service and that this is recorded.
Vision and leadership

This section is where we report on how well the service is led.

Domain 9 – Quality improvement-focused leadership

High performing healthcare organisations are focused on quality improvement. The leaders and managers in the organisation drive the delivery of high quality, safe, person-centred care by supporting and promoting an open and fair culture of continuous learning and improvement.

Our findings

Quality indicator 9.4 - Leadership of improvement and change

The service had an enthusiastic and motivated management team. A clear and comprehensive continuous quality improvement plan was in place to improve the quality of care. An evaluation system should be developed which should include staff views.

In recent times, the service has gone through a period of extreme change. This has included changes to the provider, senior and local management, working practices and information technology (IT) systems. At the time of the inspection, there was no permanent manager in place at the hospital. A new manager had recently been appointed to the service and was due to take up post at the end of August 2020.

We spoke with the two consultant psychiatrists, the operations director, the deputy operations director and the regional quality assurance manager. The senior management team appeared to be enthusiastic and motivated. They were keen to provide evidence of the changes they had made to improve the quality of care. We noted a very consistent understanding and acknowledgement of the challenges the service has experienced and how these were being addressed. In particular, at this time, they felt the service had to support the frontline care staff.

The quality assurance manager told us that, while they had a regional responsibility, their immediate priority and focus was to support staff through the changes the provider wished to implement. In particular, implementing a culture of promoting patients’ choice and protecting their human rights.

Staff we spoke with told us they had experienced a period of great uncertainty since the last inspection. This was due to the previous manager leaving, the implementation of new working practices including new information technology.
systems, and the current COVID-19 pandemic. However, they felt that the service and working practices were improving. They told us the interim senior management team was approachable, and that the staff meetings were useful as they provided them with an opportunity to express their views and they felt listened to.

The service’s newly developed local overarching action plan acted as its continuous quality improvement plan. This detailed a series of internal audits that were taking place to provide a benchmark for safe staffing levels, auditing of patient care and governance issues.

In the action plan, we saw that the service had identified areas where patient care could be compromised or improved. Each area was risk assessed as red, amber or green, and an action plan was completed detailing the actions required, who was responsible and the timescales for completion.

The new electronic patient care records had a built-in system to measure any events considered to represent a risk to patients. This then flagged the identified risk to staff and the management team to take appropriate action.

**What needs to improve**
The senior management team had recognised they had to better support the nurses and support workers to achieve the level of patient care that the provider aspired to. Although staff meetings were held, and one-to-one support was available, there was no formal mechanism for staff to express their views individually or anonymously (recommendation d).

The service would benefit from formally reviewing the introduction of these changes to help the senior management team monitor the effectiveness of changes and outcome for patients.

- No requirements.

**Recommendation d**
- The service should consider how best to obtain staff views and contribute to the development of the service.
Appendix 1 – Requirements and recommendations

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement**: A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the National Health Services (Scotland) Act 1978, regulations or a condition of registration. Where there are breaches of the Act, regulations, or conditions, a requirement must be made. Requirements are enforceable at the discretion of Healthcare Improvement Scotland.

- **Recommendation**: A recommendation is a statement that sets out actions the service should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.

### Domain 5 – Delivery of safe, effective, compassionate and person-centred care

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<thead>
<tr>
<th>Requirements</th>
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| **1**  | The provider must ensure that staff are able to carry out hand hygiene at the point of care (see page 11).  
  
  Timescale – immediate  
  
  *Regulation 3(d)(i)*  
  *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* |
| **2**  | The provider must ensure that all agency staff receive appropriate education and training in COVID-19 risks and the necessary control measures (see page 11).  
  
  Timescale – immediate  
  
  *Regulation 12(c)(2)*  
  *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* |
### Domain 5 – Delivery of safe, effective, compassionate and person-centred care (continued)

#### Requirements

3. The provider must ensure its infection prevention and control policy is in line with Scottish guidance, in particular Healthcare Improvement Scotland’s *Healthcare Associated Infection (HAI) Standards* (2015) and Health Protection Scotland’s *National Infection Prevention and Control Manual* (see page 11).

Timescale – immediate

*Regulation 3(d)(i)*  
The Healthcare Improvement Scotland *(Requirements as to Independent Health Care Services)* Regulations 2011

#### Recommendations

**a** The service should ensure that any system used to manage access to the building and ward during the pandemic is reliable and effective (see page 11).

Health and Social Care Standards: My support, my life. I experience a high quality environment if the organisation provides the premises. Statement 5.17

**b** The service should ensure that all staff, including agency staff, have access to, and can demonstrate competence in, use of the electronic clinical information system (see page 13).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.23

### Domain 7 – Workforce management and support

#### Requirements

None

#### Recommendation

**c** The service should ensure that all agency staff have a period of induction in the service and that this is recorded (see page 14).

Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14
**Domain 9 – Quality improvement-focused leadership**

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<tr>
<th>Recommendation</th>
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<tr>
<td><strong>d</strong> The service should consider how best to obtain staff views and contribute to the development of the service (see page 16).</td>
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</table>

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
Appendix 2 – About our inspections

Our quality of care approach and the quality framework allows us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this approach to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

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**Before inspections**

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.

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**During inspections**

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

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**After inspections**

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: [www.healthcareimprovementscotland.org](http://www.healthcareimprovementscotland.org)

We require independent healthcare services to develop and then update an improvement action plan to address the requirements and recommendations we make.

We check progress against the improvement action plan.

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More information about our approach can be found on our website: [www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx)
Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

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Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Telephone: 0131 623 4300

Email: hcis.ihcregulation@nhs.net