The Priory Hospital Bristol

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services well-led?	

Overall summary

On 24 August 2020 we undertook an unannounced night time focused inspection at The Priory Hospital Bristol at the wards for children and young people (Banksy and Brunel wards). We returned on site during working hours on 25 and 26 August 2020 to continue our inspection of wards for children and young people, but also acute and inpatient wards for adults of a working age that we had received concerns about (Redcliffe and Upper Court wards). We also held a number of remote interviews with staff and carers that concluded on the 9 September 2020.

On 7 September 2020, following our inspection, we served the provider an urgent notice of decision to impose conditions on their registration under Section 31 of the Health and Social Care Act 2008. Section 31 of the Health and Social Care Act 2008 Act is an urgent procedure whereby CQC can vary any condition on a provider's registration in response to serious concerns. We took this urgent action as we believed that people would or may be exposed to the risk of harm if we did not do so.

The conditions placed required the provider to, within a set period of time, confirm in writing that it had enough suitably qualified and competent staff on wards at all times, reviewed all care records on Redcliffe and Upper Court, put in place robust processes for the management of medicines, ensured that all staff had an induction and had access to information to enable them to deliver safe care and could manage risks appropriately.

Summary of findings

The provider was also required to report to us on a regular basis so that we could monitor whether it was complying with the conditions. This process was ongoing at the time of publication of this report.

We only inspected areas of the service that we had received concerns about. We did not inspect the key questions of are services caring or responsive as part of this inspection. We did not inspect all aspects of the key questions of are services safe, effective and well led as part of this inspection. This means we have not changed the ratings for this service overall.

Due to an agreement between the provider and NHS England, both child and adolescent mental health wards were due to be closed by the end of September 2020 with all patients discharged to other placements or the community. As these wards are now closed, the rating for these wards does not apply.

During this inspection, we found:

There was not enough staff to ensure patients had access to planned activities and the leave they were entitled to on Redcliffe and Upper Court wards and staff confirmed this.

There were significant staffing issues on the child and adolescent wards. There were high vacancy rates for nursing posts on both wards and high vacancy rates for healthcare assistants on Brunel ward. There were high rates of sickness on across both Brunel and Banksy wards. This meant that there was high usage of agency staff who did not necessarily know the ward or patients well.

Staff did not have access to the information they needed to provide good care. The wards for children and young people had high usage of bank and agency staff, who did not have access to the electronic care records system or the incident reporting system. They did not have good sight of the risks of the ward environment because their induction was brief and did not cover all they needed to know to do their job. Paper files were incomplete and disorganised. Staff struggled to find information we requested while we were on site.

Systems and processes for safely prescribing, administering, recording and storing medicines were not always followed. Not all registered nursing staff were aware of where emergency medicines were being stored. Access to medicines for disposal was not restricted to authorised staff. Staff did not store and manage all medicines and prescribing documents in line with the provider's policy.

Processes were not in place to ensure medication to support patients challenging behaviour was used only after appropriate de escalation techniques had been tried. Staff had not documented their decision making when they did not follow national guidance in what medicines they used to rapidly tranquilise patients. When rapid tranquilisation had been administered there were no physical observations recorded as recommended by the National Institute for Health and Care Excellence (NICE) guidance.

Staff on the wards for children and young people did not always raise incidents or allegations of abuse appropriately. We found that there had been incidents recorded of young people being administered medicines against their wishes, outside of a legal framework. This had occurred multiple times and had not been reported as an incident. Further, we saw documentation that a young person had made multiple self harm attempts but these were not recorded as incidents. We saw staff had documented two safeguarding concerns in care records but had not reported these to the local safeguarding authority for investigation.

Staff had not assessed and planned patients' care around all their needs. We saw that six out of eight care plans across Redcliffe and Upper Court were not personalised and did not adequately reflect patients' views. Five of these eight care plans were not recovery focused or holistic in their assessment of patients' needs.

Only 61% of staff on Redcliffe ward were up to date with their training in the Mental Health Act and only 67% were up to date with their training in the Mental Capacity Act. Staff had not always appropriately documented patients capacity or consent on Redcliffe Ward.

The hospital senior leadership team had undergone significant upheaval since our last inspection. There was a new hospital director in post, a new hospital deputy director and a new medical director since February 2020. There were also vacancies for ward managers for the wards for children and young people. A new interim hospital manager was appointed but did not start in post until after this inspection.

Summary of findings

Staff raised concerns with the culture of the wards for children and young people. Staff told us that the planned closure of the wards had affected morale of the staffing team. Staff on Brunel told us they felt undervalued. They said that there were frictions between the day shift (staffed mostly with permanent staff) and the night shift (staffed mostly with bank and agency). Agency staff on both wards said that they did not always feel comfortable raising concerns.

Governance systems were not robust enough to ensure good care at the hospital. Systems did not ensure staff were up to date with important mandatory trainings in the Mental Capacity Act and the Mental Health Act. Staff reported having good access to information but were unable to provide information to the inspection team in a timely way while on site. Systems were not in place to ensure all medicines for rapid tranquilisation were administered under a legal framework or in line with national guidance.

There were also issues with processes to ensure a suitable mix of skilled staff on shifts on the wards for children and young people. Audit processes around the quality of care records at the hospital had not ensured good clinical record-keeping.

Managers had not ensured the hospital risk register was reflective of current risks. We found that 75% of the items on the hospital risk register had actions that were out of date and did not reflect the current risks on site. It was not clear who had oversight of the risk register or where this was supposed to be reviewed.

Senior leaders in Priory Healthcare were not fully aware of the issues at this hospital until we raised these with them. This demonstrates a lack of robust oversight and assurance.

However:

The provider had addressed the blind spots and issues with anti-barricade doors raised at our last inspection.

Staff on Redcliffe and Upper Court wards knew what incidents to report and were able to demonstrate how learning from incidents had changed practice.

Staff on the wards for children and young people were more up to date with their mandatory training in the Mental Capacity Act. Ninety-four per cent of staff were up to date with their training in the Mental Capacity Act.

Staff on Redcliffe and Upper Court reported having capable, approachable leaders. They said that the ward culture was good and they were able to raise issues of concern without fear of reprisal.

Summary of findings

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The Priory Hospital Bristol

Services we looked at
Acute wards for adults of working age and psychiatric intensive care units; Child and adolescent mental health wards

Summary of this inspection

Background to The Priory Hospital Bristol

The Priory Hospital Bristol is an independent hospital registered to provide care and treatment for individuals with mental health conditions. The hospital admits patients detained under the Mental Health Act 1983 as well as informal patients, and provided the following core services:

- Acute mental health inpatient wards.
- Child and Adolescent Mental Health (CAMH) wards.
- Eating disorder ward.
- Long-stay/rehabilitation wards.

The acute mental health inpatient wards consist of:

- Redcliffe: a 13-bed acute ward for men.
- Upper Court: a 10-bed acute ward for men and women.
- Holbrooke: a 9-bed private acute ward for men and women

The child and adolescent mental health wards are:

- Banksy: a 12-bed psychiatric intensive care unit for children and young people.
- Brunel: an 11-bed ward for children and young people.

Due to an agreement between the provider and NHS England, both child and adolescent mental health wards were due to be closed by the end of September 2020 with all patients discharged to other placements or the community.

The hospital is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.

There has not been a registered manager in place since March 2020. There was a hospital director in post at the time of this inspection and they had applied to become the registered manager. However, this member of staff left the organisation shortly after this inspection.

The last comprehensive inspection of The Priory Hospital Bristol was in January 2019. At the 2019 inspection we rated the hospital as good overall and good in all key questions. However, we rated the acute wards for adults of working age as requires improvement in caring and responsive which led to a decrease in rating from good to requires improvement for that core service overall.

Following this inspection we issued three requirement notices:

- Regulation 9 (person centred care). The provider must ensure that patients on the acute ward for working age adults are involved in the development of their care plans and that these are person-centred.
- Regulation 15 (premises and equipment). The provider must address the lack of space and insufficient facilities on the acute wards and ensure these are fit for purpose. The provider must ensure the doors to lounges on the acute wards are anti-barricade and all blind spot area risks are mitigated.
- Regulation 12 (safe care and treatment). The provider must ensure effective communication between the multidisciplinary team and the staffing team on the child and adolescent mental health wards to ensure effective care and risk management.

Our inspection team

The team that inspected the service comprised three CQC inspectors, two inspection managers, two pharmacy inspectors, an assistant inspector and two specialist advisors. The specialist advisors were nurses with professional backgrounds in child and adolescent mental health services (CAMHS) and mental health services for working age adults.

Summary of this inspection

Why we carried out this inspection

We inspected two of the acute wards for working age adults, and both of the child and adolescent mental health wards because we received information giving us concerns about the safety and quality of the services.

How we carried out this inspection

We carried out an unannounced inspection visit to follow up on concerns raised with us by external stakeholders and members of the public. We carried out an unannounced night visit on 24 August 2020, followed by unannounced visits in working hours on the 25 and 26 August 2020. We finished remote interviews with staff and carers on the 9 September 2020.

We received a concern about the use of rapid tranquilisation medicine on Upper Court at The Priory Hospital Bristol on 16 June 2020. Rapid tranquilisation is a required medication, usually an injection, often used to calm an agitated or aggressive patient. The concern raised with us highlighted a number of issues with the legal framework under which the medicine was administered, the combination of medicines used, and the quality of the physical health checks after the medicine had been administered. The provider had not notified the Care Quality Commission of the incident in a timely way and only submitted a notification following a number of data requests about this incident. The provider notified us of this incident on 26 June 2020.

The provider notified the Commission of NHS England (NHSE) being on site on 2 July 2020. NHSE liaised with the provider and it was agreed that the hospital would close the psychiatric intensive care unit that cared for young people (Banksy ward). NHSE shared concerns with the Commission and other external stakeholders about staffing, incident reporting and management. Following a number of additional incidents on the other ward for children and young people, and subsequent data requests being made to the provider by NHSE and the Care Quality Commission, NHSE and the provider agreed that the hospital would close their other ward for children and young people (Brunel ward) and ensure all children and young people were safely discharged to other services by the end of September 2020.

As this was a focused inspection we only looked at parts of the key questions for safe, effective and well-led. We inspected the wards that the concerns had been raised about (Redcliffe, Upper court, Banksy and Brunel). We focused on how the provider was staffing the wards, how they managed and administered medicines, how they identified and managed risks and incidents, and the culture on the wards. Because we did not inspect all aspects of the service, we have not re-rated the service at this inspection.

Before the inspection visit, we reviewed information that we held about the location, requested information from the provider and asked a range of other organisations for information. We also conducted a Mental Health Act review at Brunel Ward to follow up on some of the concerns raised with us and get the views of young people and their carers.

During the inspection visit, the inspection team:

- spoke with the hospital director, medical director and the clinical director of the hospital
- inspected Banksy, Brunel, Redcliffe and Upper Court wards and looked at the quality of the environment including the clinic and treatment rooms
- spoke with four carers remotely
- spoke with 13 members of staff including nurses, doctors and healthcare assistants
- reviewed 14 patient care records, including 17 medicines charts
- reviewed a selection of incident reports and the learning from these and,
- looked at a range of policies, procedures and other documents related to the running of the hospital and each of the core services.

Summary of this inspection

What people who use the service say

Unfortunately, no patients provided us feedback on the service at this inspection. However, we were able to speak to four carers for patients on the wards for child and adolescents.

They told us that there were some good permanent staff on the wards, but that there were high numbers of agency staff. They said that staff sometimes had problems communicating with them and within the staff team. Three out of the four carers said they did not feel their relative was being cared for safely.

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 did not inspect all aspects of safe as part of this inspection so we have not changed the ratings in safe.

There was not enough staff to ensure patients had access to planned activities and the leave they were entitled to on Redcliffe and Upper Court ward and staff confirmed this.

There were significant staffing issues on the child and adolescent wards. There were high vacancy rates for nursing posts on both wards and high vacancy rates for healthcare assistants on Brunel ward. There were high rates of sickness on across both Brunel and Banksy wards. This meant that there was high usage of agency staff who did not necessarily know the ward or patients well.

Staff did not have access to the information they needed to provide good care. The wards for children and young people had high usage of bank and agency staff, who did not have access to the electronic care records system or the incident reporting system. They did not have good sight of the risks of the ward environment because their induction was poor. Paper files were incomplete and disorganised. Staff had difficulty finding information we requested while we were on site.

Systems and processes for safely prescribing, administering, recording and storing medicines were not always followed. Not all nursing staff were aware of where emergency medicines were being stored. Access to medicines for disposal was not restricted to authorised staff. Staff did not store and manage all medicines and prescribing documents in line with the provider's policy.

Processes were not in place to ensure medication to support patients challenging behaviour was used only after appropriate de escalation techniques had been tried. Staff had not documented their decision making when they did not follow national guidance in what medicines they used to rapidly tranquilise patients. When rapid tranquillisation had been administered there was no physical observations recorded as recommended by the National Institute for Health and Care Excellence (NICE) guidance.

Staff on the wards for children and young people did not always raise incidents or allegations of abuse appropriately. We found that there had been incidents recorded of young people being administered medicines against their wishes, outside of a legal framework. This had occurred four times and none of the occasions had not been reported as an incident. Further, we saw

Summary of this inspection

documentation that a young person had made multiple self harm attempts but these were not recorded as incidents. We saw staff had documented two safeguarding concerns in care records but had not reported these to the local safeguarding authority for investigation.

However:

The provider had addressed the blind spots and issues with anti-barricade doors we raised at our last inspection.

Staff on Redcliffe and Upper Court wards knew what incidents to report and were able to demonstrate how learning from incidents had changed practice.

Are services effective?

We did not inspect all aspects of effective as part of this inspection so we have not changed the ratings in effective.

Staff had not assessed and planned patients care around all their needs. We saw that six out of eight care plans across Redcliffe and Upper court were not personalised and did not adequately reflect patients' views. Five of these eight care plans were not recovery focused or holistic in their assessment of patients' needs.

Only 61% of staff on Redcliffe ward were up to date with their training in the Mental Health Act and only 67% were up to date with their training in the Mental Capacity Act. Staff had not always documented patients capacity or consent on Redcliffe Ward.

However:

Staff on the wards for children and young people were more up to date with their mandatory training in the Mental Capacity Act. Ninety-four per cent of staff were up to date with their training in the Mental Capacity Act.

Are services well-led?

We did not inspect all aspects of well-led as part of this inspection so we have not changed the ratings in well-led.

The hospital senior leadership team had undergone significant upheaval since our last inspection. There was a new hospital director in post, a new hospital deputy director and a new medical director. There was also vacancies for ward managers for the wards for children and young people. A new interim hospital manager was appointed but did not start in post until after this inspection.

Staff raised concerns with the culture of the wards for children and young people. Staff told us that the closure of the wards had effected morale of the staffing team. Staff on Brunel told us they felt

Summary of this inspection

undervalued. They said that there were difficulties between the day shift (staffed mostly with permanent staff) and the night shift (staffed mostly with bank and agency). Agency staff on both wards said that they did not always feel comfortable raising concerns.

Governance systems were not sufficient to ensure good care at the hospital. Systems did not ensure staff were up to date with important mandatory trainings in the Mental Capacity Act and the Mental Health Act. Staff reported having good access to information but were unable to provide information to the inspection team in a timely way while on site. Systems were not in place to ensure all medicines for rapid tranquilisation were administered under a legal framework or in line with national guidance.

There were also issues with processes to ensure a suitable mix of skilled staff on shifts on the wards for children and young people and audit processes around the quality of care records at the hospital had not ensured good clinical record-keeping.

Managers had not ensured the Hospital risk register was reflective of current risks. We found that 75% of the items on the hospital risk register had actions that were out of date and did not reflect the current risks on site. It was not clear who had oversight of the risk register or where this was supposed to be reviewed

However:

Staff on Redcliffe and Upper Court reported having capable, approachable leaders. They said that the ward culture was good and they were able to whistle-blow without fear of reprisal.

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

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Safe and clean environment

At our last inspection, we issued the provider with a requirement notice to ensure the risk from blind spots were mitigated and that doors to lounges on the ward were anti-barricade. The service had installed anti-barricade doors and convex mirrors to address blind spot risk areas. The layout of both wards allowed staff to observe all parts of the ward and most risks were adequately mitigated. However, there had been 30 incidents (28 on Redcliffe ward alone) of people who were legally detained at the ward going absent without leave due to low fencing in the exterior courtyard. Patients with good physical health were able to climb the fence. Enhanced observations were used to manage this risk; but this was not always effective.

Safe staffing

Managers had calculated the number and grade of nurses and healthcare assistants required based on a staffing ladder. The number of nurses and healthcare assistants matched this number on all shifts. The ward managers could adjust staffing levels daily to take account of case mix. However, staff we spoke with felt that staffing numbers were not sufficient to provide good quality care.

We spoke to nine members of staff, four of those told us that ward activities and Section 17 leave often had to be rearranged or cancelled due to inadequate staffing. Section 17 is the part of the Mental Health Act that allows the patients registered clinician to grant patients leave from the hospital. Section 17 leave was planned in the morning of each day. However, with limited staff numbers, if patient acuity changed, leave would need to be cancelled or rearranged and healthcare assistants (HCA) would no longer be available to facilitate activities. For each shift there were two registered mental health nurses (RMNs) and one HCA for nine patients, two RMNs and two HCAs for 10 or above. With changes to patient acuity and observation increases for some patients this left activities falling short.

Managers regularly used agency and bank nursing staff to maintain safe staffing levels. Bank and agency staff were frequently 'block booked' to help maintain consistency on the wards. When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward.

Staff had access to adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Assessing and managing risk to patients and staff

We reviewed eight patient care records, four from Upper Court ward and four from Redcliffe ward.

All patients had a risk assessment completed on admission and had it updated regularly, where incidents were reported we saw that staff had updated these assessments. However, we found that provider policy had not always been followed in referencing incidents properly in patients risk assessments.

Safeguarding

Staff on the wards were trained in safeguarding, knew how to make a safeguarding alert and did when appropriate. Staff we spoke with could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm.

Staff access to essential information

Staff used a combination of paper and electronic records across both wards.

Staff didn't always have access to all relevant clinical information in a timely way. Staff told us all information needed to deliver patient care was available to all relevant staff, including agency staff, when they needed it and was in an accessible form. However, when we requested information on site, staff had difficulty providing this information to us in a timely way.

Medicines management

Systems and processes for safely prescribing, administering, recording and storing medicines were not always followed. Not all nursing staff were aware of where emergency medicines were being stored. Access to medicines for disposal was not restricted to authorised staff.Staff did not store and manage all medicines and prescribing documents in line with the provider's policy.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines.

Mental Health Act certificates (documents indicating a patients legal status in regards to consenting to medicines while detained) were not being kept with the prescription charts so they could be checked prior to administration of medicines as recommended by national guidance.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Processes were not in place to ensure medication to support patients challenging behaviour was used only after appropriate de escalation techniques had been tried. When rapid tranquillisation had been administered there were no physical observations recorded as recommended by the National Institute for Health and Care Excellence (NICE) guidance.

Staff reviewed the effects of each patient's routine medicines on their physical health according to NICE guidance.

Track record on safety

In the last 12 months Redcliffe ward had 35 serious incidents.

Reporting incidents and learning from when things go wrong

Staff we spoke with said they felt confident in what incidents to report and how to report them. However, they did not always report these incidents to other external bodies as appropriate. Before this inspection we found that the provider had failed to notify us of an incident where a patient at the hospital had been administered medicine by staff which had led to them needing admission to a general hospital. The provider only notified us of this event after we requested further data about the incident.

Staff received feedback from investigation of incidents, both internal and external to the service. They told us about the learning that had followed the incident above, including further training being booked and changes in policies.

Staff were debriefed and received support after a serious incident. Staff had recently received debrief training from the onsite psychologist, to ensure that debriefs were effective and beneficial to all staff involved.

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

(for example, treatment is effective)

Assessment of needs and planning of care

We reviewed eight care records across both Redcliffe and Upper Court ward. Across both wards we saw that staff completed comprehensive mental health assessments of patients on admission to the ward.

At our last inspection we issued the provider with a requirement notice to ensure patients were involved in the development of their care plans and that these were person-centred. We found that there continued to be missing information in care plans. Six out of eight care plans reviewed lacked personalisation and failed to include the patient's views sufficiently. Five out of eight care plans were not holistic and did not appropriately detail patients' full range of problems and needs, and all care plans reviewed were insufficiently recovery focused. A lack of personalisation of care plans and patient involvement may result in reduced quality of care for patients that does not fully encompass their preferences and needs.

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

Adherence to the MHA and the MHA Code of Practice

All staff on Upper Court were up to date with their training in the Mental Health Act. However, only 61% of staff on Redcliffe ward were up to date with this training

Staff spoke positively about their Mental Health Act administrators and felt comfortable and confident to raise any queries with them. The Mental Health Act administrators were based onsite and staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice.

The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and there was a copy of the Code of Practice available on both wards.

Both wards had displayed a notice to tell informal patients that they could leave the ward freely.

Good practice in applying the MCA

All staff on Upper Court were up to date with their training in the Mental Capacity Act. However, only 67% of staff on Redcliffe ward were up to date with this training.

Some staff we spoke to had a good understanding of the Mental Capacity Act, in particular the five statutory principles. However, some staff did not remember the training they had received and did not believe it was important to their role. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent to treatment inconsistently. We reviewed eight care records, four from Redcliffe ward and four from Upper Court ward. On Redcliffe ward two out of four care records had no documentation of mental capacity assessment present.

Audits of the documentation of mental capacity were not sufficient to ensure good practice. Staff told us that there were frequent audits but we found poor recording in two records while on site, and poor recording of mental capacity in an incident we reviewed before this inspection.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.

Staff sought advice from the Mental Health Act administrators regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards, and felt comfortable doing so.

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

We did not inspect this key question at this inspection.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

At our last inspection we issued the provider with a requirement notice to ensure staff and patients had access to the full range of rooms and equipment to support treatment and care.

On this inspection, we found that the provider still lacked sufficient space for dining facilities and rooms for therapies and activities. There was insufficient dining space available for all service users to eat on the ward. Service users were able to use the dining and activity facilities in the main building, however for service users who are particularly unwell travelling to the main building for meal times, activities and therapy may be inappropriate or unfeasible. There were not quiet areas on the ward where patients could meet visitors.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Leadership

Both wards had managers in post at the time of our inspection, who were experienced and skilled clinicians. Both ward managers had been with the service for a number of years before their management roles and knew the hospital well. Leaders had a good understanding of the services they managed. Staff we spoke with felt that leaders were visible in the service and approachable.

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

Culture

The culture on the wards was good or being developed. All staff described their wards as happy, but demanding and busy environments. The manager and staff on Redcliffe ward had worked together previously and due to their familiarity considered themselves to be a unified team. The manager of Upper Court ward was relatively new to post, in March 2020, and told us that they were in the process of building up familiarity and rapport with the team.

Across both wards staff told us that they felt respected, supported and valued by their peers and by their managers. Staff felt positive and proud about working for the provider and their team.

All staff we spoke to felt able to raise concerns without fear of retribution. There was an open-culture on both wards and staff felt able to speak to leaders about any concerns, questions or improvement ideas.

The majority of staff knew how to use the whistle-blowing process. However, some staff did not appear familiar with the process.

Governance

We found that governance processes did not always support staff to deliver good care. Staff told us there were a range of audits (for example, around the Mental Capacity Act). However, we found these were ineffective in ensuring accurate and appropriate clinical record keeping.

Systems in place to ensure that there were adequate numbers of trained staff did not always work well. We found that only 61% of staff were up to date with their Mental Health Act training and 67% were up to date with their training on the Mental Capacity Act on Redcliffe Ward. This ward admitted patients detained under the Mental Health Act and if staff are not correctly trained, it is possible that they will unknowingly infringe the patient's human rights.

Staff told us they had easy access to the information they needed to manage service performance and ensure high quality care. However, during this inspection we made several requests for information that the provider was unable to supply within an appropriate time frame. Staff on site also had significant difficulty in giving members of the inspection team access to important clinical records and incident reports.

Staff told us that they knew how to report incidents, and that there were processes for them to follow to notify external bodies when incidents had occurred (where appropriate). However, prior to this inspection, we found evidence that this had not happened for an incident.

Management of risk, issues and performance

Managers had not ensured the Hospital risk register was reflective of current risks. We found that 75% of the items on the hospital risk register had actions that were out of date and did not reflect the current risks on site. It was not clear who had oversight of the risk register or how this was reviewed.

Child and adolescent mental health wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are child and adolescent mental health wards safe?

Safe and clean environment

Safety of the Ward Layout

Staff on Banksy ward were knowledgeable about the risks on the ward. We saw that there was a substantive member of staff on duty managing ward security on the night shift. They were knowledgeable about the risks of the ward.

However, staff on Brunel ward were not knowledgeable about all of the risks of the ward. The night shift we observed at Brunel ward was staffed predominantly by agency, with one member of bank staff. Staff only had the risk assessments provided in the handover from the previous shift which did not include all of the risks in the ward environment.

Safe Staffing

Nursing Staff

There were significant staffing issues on Banksy and Brunel wards. Banksy ward had open vacancies for all of its 11.9 whole time equivalent (WTE) qualified nursing posts but they were fully staffed for their 20.2 WTE healthcare assistants. Brunel ward had vacancies over half of their 6.6 WTE qualified nurses (only 3 WTE in post) and vacancies for over half of their nursing assistants (14.1 WTE vacancies vs 25 WTE established level).

Sickness rates were high on both wards. Sickness rates on the wards between August 2019 and September 2020 were 70% for Banksy and 46% on Brunel. Staff turnover was 25% on Banksy and 9% on Brunel wards.

Senior leadership at the hospital told us they had put a policy in place to help ensure consistency for patients. They told us they tried to ensure that there was at least one permanent member of staff on shift, and would ensure there was at least one member of agency or bank staff that had worked there for five shifts without incident. We requested staffing rotas to confirm this, but staff were unable to provide us with correctly labelled rotas to indicate if this had happened. They acknowledged that though they had put these measures in place, they weren't always followed. The provider gave us information that between August 2019 and September 2020 there was an average of 18.6% permanent nurses a shift on Banksy ward and on average 77.8% of healthcare assistants were permanent staff across the shifts in that time. Across the same time period, on average there 34% of the nursing staff were permanent and 59% of healthcare assistants were permanent.

The hospital used staffing ladders to increase core staffing in line with patient numbers. However, managers were able to book additional staff to ensure that there was enough staff to complete clinical observations of children and young people.

Bank and agency staff did not receive a standard and complete induction to the ward. Agency staff on Banksy ward told us they had received the same induction training as substantive members of staff. However, staff on Brunel ward had received significantly less induction. Substantive staff had a five day course to include training they would need to work on the ward, staff told us that agency staff sometimes had only a 30 minute induction of Banksy ward before working there and that this was true for agency staff that had been 'block booked' to help to ensure consistency.

Medical Staff

Staff had quick access to an on call doctor based on site. There was also a list of on call consultant psychiatrists that the on call doctor could call for support.

Assessing and managing risks to patients and staff

Child and adolescent mental health wards

We reviewed six care records of young people across the two wards. Staff had used the standardised risk assessment used on their care notes system to assess children and young peoples' risks. They had completed these assessments on admission and where incidents had been reported, we saw that staff had updated these assessments. However, they had not always followed the provider policy by including the reference number for the incident that had demonstrated the change in risk.

Management of patient risk

Staff received information about a patient's specific risk issues via handover between shifts and through accessing the risk assessments on the electronic records system. Patient's paper files had some risk assessments in them as well. However, because of the issues with accessing the care records system for agency staff, and the high usage of agency staff (especially on night shifts at Brunel) this meant in practice that agency staff had to rely on the handover information between shifts. We saw that a patient had raised concerns about possible abuse but staff had not raised this as an incident and so the risks had not been managed.

There had been incidents on the wards of children and young people swallowing batteries. This had led to staff using the providers search policy to search the ward for batteries and the introduction of a temporary restriction on the presence of batteries on the ward. Despite this information being shared with staff through handover, and three searches of the environment, a young person was able to self harm by swallowing batteries.

Staff said they used restraint only after de-escalation had failed and were trained in how to restrain young people safely.

Staff received training on the Mental Capacity Act and Mental Health Act but did not always follow these legal frameworks when using chemical restraint (i.e. rapid tranquilisation medicines). We saw that staff had administered intramuscular promethazine to a single young person outside of the legal framework of the Mental Capacity Act and Mental Health Act on four occasions. Staff had not identified this as a concern, nor had they reported it to the local safeguarding authority until prompted to by the inspection team.

Staff did not always follow national guidance from the National Institute for Health and Care Excellence (NICE) when using rapid tranquilisation. We reviewed the medicines charts of five young people and found three were prescribed intra-muscular promethazine which is against national guidance for children and young people. Staff were unable to show us the rationale behind prescribing this to the young people. We saw that this medicine had been administered 48 times to three young people but post administration medical checks (recommended by national guidance) were only completed on five of those times. Intra-muscular medicines for the rapid tranquilisation of aggressive patients pose a risk of over sedation and respiratory side effects, medical checks of the patients vital signs help to reduce risk to life. In total, staff had recorded administering rapid tranquilisation medicine 270 times to patients in the year leading up to this inspection.

We requested information from the provider about the use of restraint. There had been two uses of long term segregation on Banksy ward. The provider reported 359 incidents of restraint in the year before this inspection on Brunel ward and 270 on Banksy ward. Staff had restrained young people in the prone position (face down on the floor, which increases risks of suffocation) four times in this time period. Staff told us that Priory policy was to not restrain patients in the prone position.

Safeguarding

Permanent staff received training on how to safeguard vulnerable people and children, and report allegations of abuse. Senior managers at the hospital told us that this was also completed by agency staff that had been booked for longer term contracts (those that were being used as locum staff). This was delivered as part of a five day training course. However, not all of the agency staff that were being used for long term cover had received this training. Staff on Banksy ward told us they had received it, but agency staff at Brunel ward told us they had not received this training.

Staff had access to prompts and a flow chart to follow in the office should they identify any allegations of abuse. However, when we reviewed care records, we saw that there had been two allegations of abuse that had not been reported appropriately, these included ongoing risks. The provider raised this with the local authority after we made them aware of the allegations. After the site visit, the

provider reviewed the care records of young people at the hospital and found another two incidents that they felt should have been reported to the local safeguarding authority but were not.

Staff access to essential information

Not all staff had access to all relevant information needed to safely provide care. Both wards for children and young people used agency staff to ensure they met minimum staffing numbers. However, agency staff did not have full access to the electronic record system or incident reporting system. Agency staff that were booked for longer terms (locum) were given access but these log ins had expiry dates that meant not all of the staff working there still had access. There was a general log in for agency staff but this only gave access to the providers policies.

Staff told us this was more of an issue on Brunel ward, due to the high usage of agency staff at night. They said that it was common for them to have to call around the hospital to find someone to come and log them onto the system so they could update care records at the end of the shift. This meant that on the night of our inspection visit (24 August) there was only one member of staff on Brunel ward with a log in and access to electronic care records. We reviewed six of the paper record folders used across the two wards and found that these folders were disorganised. Some had a filing system that seemed to be standardised, others did not follow this structure. The files were used to hold observation record sheets (for use with clinical observations to manage patient risk) but these sheets were not ordered, with some missing.

This meant that the only consistent information that agency staff had access to was the shift handover, which focused mainly on the risks from the last shift. This gap in access to information meant the provider could not be assured staff had full access to the information needed to safely provide care.

Medicines Management

Systems and processes for safely prescribing, administering, recording and storing medicines were not followed. Monitoring of young people's physical observations following rapid tranquilisation was not always completed.

Staff reviewed young people's medicines regularly and provided specific advice to children, young people and carers about their medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines for disposal and medicines which had been delivered were not locked away and access was not restricted to authorised staff.

Staff followed current national practice to check young people had the correct medicines.

The service had systems to ensure staff knew about medication safety alerts and incidents.

Processes were not in place to ensure medication to support patients challenging behaviour was used only after appropriate de escalation techniques had been tried. One person was administered rapid tranquillisation without a legal framework in place to allow to staff to administer. Guidance for staff to explain when a medicine which had been prescribed to be taken 'when required' was not available.

Staff reviewed the effects of each patient's regular medication on their physical health according to NICE guidance.

Track record on safety

The provider reported seven serious incidents in the year before this inspection. These incidents included an incident of estates damage that needed repair, and multiple incidents of self harm.

Reporting incidents and learning from when things go wrong

Staff told us they knew what incidents to report. However, we saw that they had not always followed the providers policy in referencing incidents in patient's risk assessments. Staff had recorded multiple ligature attempts in one young person's observation records, but had not subsequently reported these as incidents. A ligature attempt is where someone attempts to use a cord or rope for the purpose of self harm, typically strangulation. Furthermore, even when incidents were reported through the incident reporting system this did not always lead to staff raising the incident with the appropriate external body. We found that staff had reported a young persons

Child and adolescent mental health wards

allegations of abuse as an incident, but had not raised this with the local safeguarding authority to investigate. Once we made the provider aware of this oversight, they notified the local authority.

Staff understood the duty of candour (being open and transparent) and when they reported incidents, staff complied with this duty.

Staff said that it was difficult to organise meetings to share learning from incidents in a formal way. Some agency staff told us that they were not included in debriefs after incidents. Staff told us they discussed incidents informally during handovers, and that these handovers included relevant learning from incidents.

Between April 2020 and leading up to this inspection, we were made aware of a number of incidents with similar trends. For example, young people swallowing batteries. We saw that the provider had put some actions in place (restricting batteries on the wards, completing searches of the environment) but that these measures had not been sufficient in reducing the risks of re-occurrence of these incidents.

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

Good practice in applying the Mental Capacity Act

At the last inspection, we said the provider should ensure that staff received training on the Mental Capacity Act and be knowledgeable about the Gillick competency (a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or consent).

Staff reported receiving training on the Mental Capacity Act and were aware of the key principles of the Act. The provider supplied us information that showed 94% of staff had completed or were completing their mandatory training on the Mental Capacity Act. However, while we saw that staff were recording consent in care records, we saw they had administered intramuscular medicines to one patient on four occasions against their wishes outside of the remit of the Mental Capacity Act. We raised this with the provider at the time of inspection and they notified the local safeguarding authority.

Are child and adolescent mental health wards caring?

We did not inspect this key question at this inspection.

Are child and adolescent mental health wards responsive to people's needs?
(for example, to feedback?)

We did not inspect this key question at this inspection.

Are child and adolescent mental health wards well-led?

Leadership

Neither ward had a permanent ward manager in post. Both wards were being managed by the deputy ward managers who were both new in post. Both acting managers were skilled and experienced clinicians.

Culture

Ward culture was different on both wards and staff told us they had concerns on both of the wards. Staff told us that the culture on Banksy had improved with the recent appointment of a director of clinical services. Staff reported feeling supported by this new manager, but felt that the upcoming closure of the ward had negatively effected morale in the staff team. Staff reported that there had been some issues on the ward with some agency staff making inappropriate comments to female members of staff but that managers at the hospital had taken swift action to address these issues. Staff also told us that there were some issues with white male staff feeling uncomfortable meeting the needs of young people from black or ethnic minority backgrounds. Specifically that a small number of staff seemed to be more nervous around young people from this background.

Staff on Brunel ward told us that there was a distinct difference between staffing groups on the night and the day shift, with permanent staff working mostly day shifts

and the staffing being mostly agency at night. Staff reported feeling undervalued and drew our attention to the fact the staff toilet was out of order and the staff office was in poor repair. Staff told us that there were issues between day shift and night shift teams, with the day shift not always following therapeutic boundaries with young people. They said this led to young people complaining when staff on the night shift tried to implement care plans. Staff felt that managers did not appropriately manage these complaints and would stop the agency staff member from working at the hospital again based on them trying to follow the young person's care plan.

Agency staff on both wards raised concerns with us about their comfort in raising concerns through the providers whistleblowing policies. Staff had access to whistleblowing protocols and this information was prominently displayed. However, staff told us that they did not feel comfortable raising concerns if they were not substantive members of staff as they reported the immediate response would be to not employ the staff member for future shifts.

Staff from both wards told us that they rarely saw senior leadership from the provider above the hospital director and deputy hospital director. They also told us that out of hours support was variable, with one night co-ordinator being very approachable and supportive but the other not being available when needed.

Staff told us that they only felt they could raise concerns anonymously with CQC. During this inspection we had two anonymous whistleblowing notifications from staff about a rapidly organised move of all children and young people from Brunel to Banksy ward. They were concerned staff had not even toured the new ward, and that patient's risks of transfer had not been assessed. They felt this move would negatively impact young people in their care. We raised these concerns with the provider, who delayed the move to allow staff to tour the new ward and assess the risks of moving the children and young people to Banksy ward.

Governance

We did not find robust evidence of comprehensive assurance systems, to escalate performance issues appropriately. The current governance systems were not sufficiently embedded to provide adequate oversight and monitoring of the quality and safety of the service. Clinical governance meetings were not effective at improving quality or having a demonstrable impact on quality improvement at the hospital.

Systems and process were poor around the use of rapid tranquilisation medicines. They were not sufficient to ensure that medicines for rapid tranquilisation were administered under appropriate legal frameworks. There weren't sufficient checks in place to ensure staff did not prescribe medicines which were not recommended for young people (or document the justification for prescribing these medicines). Systems did not ensure that staff appropriately monitored the physical health of young people after administering the medicines.

Further, governance systems did not ensure there was an appropriate mix of experienced staff that were familiar to the young people on each shift. The quality assurance systems had not identified issues with access to care records and we found evidence in care records of incidents not being reported in line with the provider's policy or being reported to local safeguarding authorities as appropriate.

Management of risk, issues and performance

Managers had not ensured the hospital risk register was reflective of current risks. We found that 75% of the items on the hospital risk register had actions that were out of date and did not reflect the current risks on site. It was not clear who had oversight of the risk register or where this was supposed to be reviewed.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Physical observations must be completed following the administration of rapid tranquillisation.
- Legal authority to administer medicines must be in place before administration without patient consent.
- The provider must ensure processes are in place to ensure medication to support patients challenging behaviour is used only after appropriate de escalation techniques have been tried
- The provider must ensure that patients on the acute wards for adults of working age have access to appropriate facilities to allow their needs to be met. This includes rooms that can be used for activities and facilities for patients to eat together on the ward.

Action the provider SHOULD take to improve

- MHA certificates should be kept with prescription charts as recommended by the medicines policy and national guidance.
- Guidance should be available for staff to decide when to administer a medicine which has been prescribed to be taken when required and should be part of a patient centred care plan.
- All staff should know where to access emergency medicines in the event of an emergency.
- Access to all medicines should be restricted to authorised staff.

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 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15: Premises and equipment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 The environment did not allow patients enough room for them all to eat in the dining room and there was not appropriate access to rooms for therapies and activities. The facilities were not suitable for the purpose of which they were being used. This was a breach of regulation 15 (1)(c).

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 Regulation 12: Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Physical observations were not completed in line with national guidance following administration of rapid tranquilisation medicines. Staff had administered medicines to rapidly tranquilise patients against national guidance with no clinical decision making recorded. Staff had administered medicines outside of their legal authority. These combined demonstrate unsafe management and administration of medicines. This was a breach of regulation 12 (1)(2)(g)

This section is primarily information for the provider

Enforcement actions

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 18 HSCA (RA) Regulations 2014 Staffing Regulation 18: Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 There was a high use of agency staff on child and adolescent wards that were not fully inducted into the ward. Staffing numbers did not allow for activities or for leave (and these were cancelled). This was a breach of regulation 18 (1)(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9: Person-centred care Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 Agency staff on child and adolescent wards did not have easy access to information necessary to provide care, care records had information missing and were not complete. Care plans were not personalized and recording was inconsistent on the acute wards for adults of a working age This was a breach of regulation 9 (1)(2)(3)(b)

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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 **Regulation 12: Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12** There was insufficient guidance for staff to safely administer 'as needed' medicines where multiple 'as needed' medicines had been prescribed. This was a breach of regulation 12 (1)(2)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17: Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17** Incidents had not always been reported or referenced in line with policy. This meant systems to monitor and improve the quality of services were not sufficient. This was a breach of regulation 17 (1)(2)(b)(f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13: Safeguarding service users from abuse and improper treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13** A young person had received rapid tranquilisation against their wishes while an informal patient. This young person had not been protected against improper treatment. Safeguarding concerns were not always reported to the local authority appropriately to ensure investigation and to safeguard young people.

This section is primarily information for the provider

Enforcement actions

This was a breach of regulation 13 (1)(2)(3).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11: Need for consent Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11** **Capacity and consent were inconsistently recorded on acute wards for adults of a working age. Staff could not demonstrate they only provided care and treatment with appropriate consent.** **This was a breach of regulation 11 (1).**