Cheadle Royal Hospital

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?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

This was a focused unannounced inspection just looking at the safe domain of the child and adolescent mental health wards at Cheadle Royal Hospital.

Our rating of safe of the child and adolescent mental health wards at Cheadle Royal Hospital stayed the same. We rated it as requires improvement because:

- We found that the provider's policy on prevention and management of disturbed/violent behaviour was not

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being followed when prescribing "when required medicines". The policy stated that prescribing should be tailored to the patient and be part of their individual plan. It should not be administered routinely or automatically and should be reviewed regularly. One patient had no record of a review of the need for two "when required" medicines even though these had not been administered for five and nine months respectively.

- Staff did not directly record incidents onto the hospital's electronic system, instead a separate paper system had been developed where staff completed a form and another member of staff then entered the details into the electronic system at a later date. We found the paper system to be poorly maintained with loose sheets and a back log waiting to be uploaded. There was no audit for this process, so the hospital could not be certain that incidents were being accurately recorded.
- The record of physical observations that had taken place after the administration of rapid tranquilisation were poorly organised although we were confident the observations were taking place in practice. We found post rapid tranquilisation forms which had been completed but were stored in different locations, for example we examined 27 records of episodes of intramuscular administration recorded on prescription charts and 19 of these had no post rapid tranquilisation monitoring form attached.
- We found inconsistent recording within care records. We saw examples where incidents were not included in notes and information was recorded in different places.
- Mental Health Act paperwork was not always completed in relation to patients' treatment.

However:

- The wards were clean and tidy and being renovated to improve safety.
- Staff assessed and managed risks. There was a comprehensive risk assessment for all patients and a daily communication sheet provided for staff which included all patient risks.

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Background to Cheadle Royal Hospital

Cheadle Royal Hospital is part of Affinity Healthcare Limited (operating as the Priory group) located in Cheshire and has been registered with the Care Quality Commission since December 2010. The hospital provides a range of mental health services including inpatient services for adults.

The hospital was registered with the CQC to provide the following regulated activities and there was a registered manager in place:

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

The child and adolescent mental health wards consisted of three wards:

- Orchard Ward mixed gender 15 beds
- Meadows Ward mixed gender 10 beds
- Woodlands Ward female low secure 10 beds

The child and adolescent mental health wards were last inspected in August 2017 and were rated as good overall but safe was rated as requires improvement with the following requirement notices.

- The provider must ensure that patients do not experience pain when subject to physical intervention.
- The provider must ensure that the monitoring and recording of patients post rapid tranquilisation is in line with policy.

Our inspection team

The team that inspected the service comprised four CQC inspectors and a member of CQC medicines optimisation team.

Why we carried out this inspection

We inspected one core service at Cheadle Royal Hospital which was the Child and Adolescent Mental Health wards. This inspection was unannounced and was in response to a notification received by CQC relating to a medicine incident. This inspection was conducted to check that patients were receiving safe care and were protected from avoidable harm. This inspection looked at the key questions relating to safe. We did not look at the key questions of caring, effective, responsive and well led at this inspection.

How we carried out this inspection

To explore the concerns raised we asked the following question of the provider:

• Is it safe?

This inspection was unannounced, which means that the provider did not know we were coming.

Before the inspection visit, we reviewed information about the location and requested additional information from the provider.

During the inspection visit, the inspection team:

- visited three wards and looked at the quality of the ward environment
- observed how staff cared for and interacted with patients
- spoke with nine patients
- spoke with four relatives or carers of patients
- spoke with managers or deputy managers for all wards

Summary of this inspection

- spoke with 11 other staff members from different disciplines including nursing, healthcare assistants and other health professionals.
- looked at 17 patients' care and treatment records
- looked at 19 medicine charts
- looked at a range of policies, procedures and other records relating to the running of the service.

What people who use the service say

We spoke with nine patients. Patients on Meadows and Woodlands said that staff cared about their recovery. They told us that staff were approachable and treated them with respect, all had access to advocacy services. All patients felt safe and were able to access support when needed.

However, patients on Orchard felt that staff constantly changed and that during the night in particular, there was a high reliance on bank or agency staff. They also raised concerns about new rules recently introduced around the availability of snacks.

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?

Requires improvement 

We rated this key question as requires improvement. We found:

- We found that the provider's policy on prevention and management of disturbed/violent behaviour was not being followed when prescribing "when required medicines". The policy stated that prescribing should be tailored to the patient and be part of their individual plan. It should not be administered routinely or automatically and should be reviewed regularly. One patient had no record of a review of the need for two "when required" medicines even though these had not been administered for five and nine months respectively.
- Staff did not directly record incidents onto the hospital's electronic system, instead a separate paper system had been developed where staff completed a form and another member of staff then entered the details into the electronic system at a later date. We found the paper system to be poorly maintained with loose sheets and a back log waiting to be uploaded. There was no audit for this process, so the hospital could not be certain that incidents were being accurately recorded.
- The record of physical observations that had taken place after the administration of rapid tranquilisation were poorly organised although we were confident the observations were taking place in practice. We found post rapid tranquilisation forms which had been completed but were stored in different locations, for example we examined 27 records of episodes of intramuscular administration recorded on prescription charts and 19 of these had no post rapid tranquilisation monitoring form attached.
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However:

- The wards were clean and tidy and being renovated to improve safety.

Summary of this inspection

- Staff assessed and managed risks. There was a comprehensive risk assessment for all patients and a daily communication sheet provided for staff which included all patient risks.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

On this inspection we did not look at Mental Health Act responsibilities.

Mental Capacity Act and Deprivation of Liberty Safeguards

On this inspection we did not look at the Mental Capacity Act.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Requires improvement	N/A	N/A	N/A	N/A	Good
Overall	Requires improvement	N/A	N/A	N/A	N/A	N/A

Notes

Good

Child and adolescent mental health wards

Safe | Requires improvement

Are child and adolescent mental health wards safe?

Requires improvement

Safe and clean environment

The wards were visibly clean and tidy. Two of the wards needed some routine maintenance. Meadow ward was in need of re-decoration and Orchard ward had a faulty roof allowing water into a de-stimulation room, which had been closed for repair. The provider was in the middle of refurbishing these wards with its “safer rooms” programme and provided evidence that these repairs had been identified and they had an estates programme in place.

The ward improvement schedule was complemented with environmental assessments undertaken using quality 'walk arounds' with senior staff and patient input from community meetings.

Meadows and Orchard wards were mixed sex. The wards complied with guidance on same sex accommodation. All patients had single bedrooms with ensuite facilities, lounges could be designated for male or female occupation.

The ward layouts did not allow staff to observe all parts of the ward and there were blind spots across all the wards, which were documented and assessed as part of the six monthly ligature audits. The use of mirrors and staff observation were initiated where concerns were identified. Staff had nurse call systems to summon support. Call alarm systems were in place for staff and patients. Staff were adequately trained in the use of personal alarms, which were tested at regular intervals. There was closed circuit television in the communal areas of the wards which staff could view, if necessary. For example, following an incident to establish what happened.

There were fire alarm call points and extinguishers on all wards and health and safety checks were undertaken with faults identified and actioned. Regular alarm checks were undertaken and staff were aware of the local fire procedures including ward evacuation.

All wards had their own clinic room, which was fully equipped, this included access to emergency equipment and emergency drugs that were checked regularly. Staff checked fridge temperatures daily and records were up to date. In each of the clinic rooms there was equipment such as weighing scales, blood pressure machines which were calibrated and, where required, an examination couch.

Each ward had access to seclusion facilities if required. The seclusion rooms met with the requirements of the Mental Health Act Code of Practice. The seclusion room on Woodlands had been refurbished using a specialised material, which became softer if patients banged it. Staff also used this room to nurse patients who were engaging in self-harm behaviours. Staff explained this meant they could nurse patients in a safe place without them causing harm to themselves and without the use of restraint for short periods.

The environment was cleaned daily and cleaning records were up to date. Staff adhered to infection control procedures.

Safe staffing

There was a sufficient range of skilled staff delivering care to patients on the ward. This included nurses, doctors, activity workers, occupational therapists, education staff, social workers, psychologists, psychotherapists and dietitians. Staff were experienced and appropriately qualified to carry out their roles.

Staffing was calculated using a staffing ladder/safe staffing tool. Staff rotas demonstrated that actual staffing levels and the skill mix reflected the numbers of staff planned. Cover for staff absence was provided with the use of bank and agency staff.

The ward manager was able to adjust staffing levels in accordance with patient need and a qualified nurse was present on the ward at all times. Patients were able to have regular one to one time with nurses and there were enough nurses to facilitate escorted leave.

The staffing complement for the wards was:

Establishment levels: qualified nurses (whole time equivalent)

• Meadows 10.7

• Orchard 10.7

• Woodlands 8.6

Establishment levels: nursing assistants (whole time equivalent)

• Meadows 26.2 (Actual 33.8)

• Orchard 21.9 (Actual 34.56)

• Woodlands 19.7 (Actual 28.39)

At the time of our inspection, vacancies for each of the wards were as follows:

Number of vacancies: qualified nurses (whole time equivalent)

• Meadows 2.48

• Orchard 4.78

• Woodlands 0

There were no nursing assistant vacancies.

The percentage of shifts covered by bank or agency staff to cover sickness, absence or vacancies in the last three months was:

• Meadows bank 8.95% agency 20.62%

• Orchard bank 15.6% agency 15.87%

• Woodland bank 21.92% agency 5.07%

Staff sickness rate in the last twelve months:

• Meadows 9.9%

• Orchard 6.1%

• Woodland 5.8%

Number of staff leavers over the last twelve months:

• Meadows 12

• Orchard 16

• Woodland 2

Medical cover for each ward was provided by a consultant psychiatrist. Speciality grade doctors were based on each ward during working hours. Outside of these hours, there was an on-call rota and doctors attended the ward when required.

The overall compliance rates for mandatory training for qualified and unqualified staff on the child and adolescent wards was 87%.

Managers monitored the compliance rates electronically for their own ward. They were alerted when training was due to expire in order to book staff on in advance of this happening.

Assessing and managing risk to patients and staff

We reviewed 17 care records as part of our inspection. Each patient, except one patient who had complex needs and was still being assessed following admission, had a complete and up to date risk assessment. Risk assessments were completed to a high standard and contained crisis plans which were individualised and included the patient views. These reflected recent incidents and what risks were assessed as part of an ongoing process.

Staff were also provided with a daily communication sheet, which included each patient's current risk assessment. Each member of staff had a copy and it was a quick reference point.

However, we found one incident involving an assault on a staff member, which had been recorded on the staff handover document, but was not included in the patient records. Staff recorded notes on a separate document and then transferring those notes onto the care records system. This meant that not all records were complete and recorded in one place and there was a risk that records were not accurate.

Some patients were restricted from entering their bedrooms at certain times. This was subject to individual risk assessments. On Orchard, one patient raised concerns that they had been subjected to prevention of violence and aggression holds to remove them from their bedroom. On examination of their care plan under keeping safe, there was a clear best interest decision that they should leave their bedroom between 9am and 4pm to socialise as when left to stay in their bedroom, their risks escalated.

At the last inspection patients had raised concerns they had been subjected to pain during physical interventions. We issued a requirement notice relating to regulation 2 for safe care and treatment. Immediately following that inspection, we received assurances that the provider had changed their training and on this inspection, we examined

the curriculum and those holds were no longer taught. In addition, none of the patients we spoke with raised issues about pain whilst being physically restrained. This meant the provider has now met the requirement notice.

Seclusion records confirmed staff were conducting checks in line with the hospitals seclusion policy. We looked at how many seclusion episodes had been recorded for July, August and September prior to our inspection. There had been 15 incidents on Woodlands, 53 incidents on Meadows Ward and six incidents on Orchard.

We also looked at the incidents of rapid tranquilisation. There had been 19 incidents on Woodlands, 40 incidents on Meadows and three incidents on Orchard. Staff told us they monitored the physical health of patients post rapid tranquilisation and we did see evidence of this.

We found post rapid tranquilisation forms which had been completed but were stored in different locations, for example we examined 27 records of episodes of intramuscular administration recorded on prescription charts and 19 of these had no post rapid tranquilisation monitoring form attached.

Staff were not fully clear about where post rapid tranquilisation forms should be stored and therefore recorded. On Meadows ward, we saw rapid tranquilisation physical health observation forms within a separate incident reports folder. We found two of these observation forms related to incidents which had not been included on the hospital tranquilisation audit database. This meant that we could not be fully assured the hospital had full oversight of incidents of rapid tranquillisation.

Meadows Ward is a secure psychiatric intensive care unit and this meant that the nature of patients illness on that ward were in the more acute phase compared to those patients on Woodlands or Orchard. The figures for seclusion and rapid tranquilisation reflected this.

Safeguarding

Staff demonstrated a good understanding of the local safeguarding procedures.

Local safeguarding procedures provided guidance for staff on their responsibilities for the safety and wellbeing of patients with responsibilities for those patients who are less able to protect themselves from harm, neglect or abuse.

Safeguarding training was mandatory for all staff and 88% of staff had completed this training. Staff gave examples of safeguarding incidents and knew how to report and escalate concerns relating to patient safeguarding.

Staff access to essential information

Staff used electronic care records and incident reporting systems. All staff had access to the electronic systems in place and there was a procedure in place to enable access to the system for agency staff.

Information governance procedures guided staff to enable compliance with the law and assess whether information was handled correctly and protected from unauthorised access, loss, damage and destruction.

Medicines management

We found that medication charts were not personalised to the patient and the provider's policy on prevention and management of disturbed/violent behaviour was not being followed when prescribing "when required medicines". The policy stated that prescribing should be tailored to the patient. It should not be routine or automatic and should be reviewed regularly. The rationale for medicines should be planned by a management team and include a clear rationale as part of a care plan.

We examined 19 medicine charts and found errors in eight charts.

Medication plans on prescription charts were not personalised to the patient. Patients had multiple medicines prescribed for management of agitation with no differentiation between those medications. Staff could decide which of these medications to use.

For example, one patient received 11 separate administrations of medicines to manage their agitation from admission at 9pm on the 9 September 2019 to 11:50am on the 11 September 2019. There was a choice of five different medicines to use with no clear advice on which one to use for which circumstances. They were prescribed as when required for use in agitation. There were no additional instructions in the care plans for staff to follow. This meant staff were left to choose which medication they would use.

One patient had a prescription for a once only dose for medicine that had both the oral and intramuscular route prescribed on the same prescription. It was not possible to

determine from the prescription if the patient had received the medicine via the intramuscular route or orally. This prevented an understanding of whether the post rapid tranquilisation observations had been completed, hospital policy stated they should indicate which route on each prescription.

One patient had no review of the need for "when required" medicines, despite these having not been administered for nine months.

Two of the prescriptions for intramuscular medicines were signed as being administered, then crossed through. It was not possible to determine if these medications had been given from the prescription chart.

We found that where required, the relevant legal authorities for treatment were generally in place for patients detained under the Mental Health Act. However, compliance with the use of section 62 (urgent treatment) had not always occurred. On Woodlands, we found a section 62 had been completed late and we were unable to find two section 61 documents.

Track record on safety

All incident reports were reviewed by senior managers during operational meetings. All serious incidents requiring an investigation were subject to a situation, background and assessment review and recommendations were identified following this. Part of this process involved ensuring that duty of candour and relevant legislation was adhered to and a team incident review would be scheduled.

Reporting incidents and learning from when things go wrong

On Woodlands ward, we found that incidents were directly reported onto an incident recording system. However, on Meadow and Orchard wards this was not the case. On Orchard ward, staff who witnessed an incident completed a paper form, which they deposited in a metal basket. On Meadows ward, staff completed a register which was in a lever arch folder. This folder was poorly maintained with some papers being loose and easily lost. A member of staff was then to input these forms onto the electronic database at some undetermined time in the future.

An examination of the log determined that staff did not complete the form properly and there was no system in place to ensure each incident was recorded onto the electronic register. The rationale for this system was it saved the time staff spent on the computer recording incidents.

There was no auditing process for this system to ensure that all incidents were uploaded. As a result, the hospital data for incidents was not reliable.

Duty of Candour

A duty of candour policy was in place and all staff we spoke with were aware of the policy and could describe the steps necessary when something went wrong and when an apology was required.

Where incidents had the potential to cause harm, the duty of candour procedure had been followed. Staff apologised to patients and carers, involved them in the investigation process, and informed them of outcomes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that effective systems are in place to accurately record incidents. Regulation 17 (1)(2)(a)(b).
- The provider must ensure that staff record and store post rapid tranquilisation monitoring forms and that process is monitored. Regulation 12(2)(a)(b)(g).
- The provider must ensure staff follow the prevention and management of disturbed/violent behaviour policy by keeping the use of 'when required' medication under review. Regulation 12(2)(a)(b)(g).

Action the provider SHOULD take to improve

- The provider should ensure that patient records are recorded contemporaneously within the hospital records systems.
- The provider should ensure the appropriate Mental Health Act paperwork is completed in relation to treatment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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.