The Priory Hospital Middleton St George

Quality Report

Middleton St George
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Date of inspection visit: 20 and 21 September 2020
Date of publication: 02/12/2020

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	Inadequate
Are services safe?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Ted Baker
Chief Inspector of Hospitals

Overall summary

We have taken enforcement action against the registered provider in relation to our concerns about this location.

Our rating of The Priory Hospital Middleton St George went down because we found a significant deterioration in the quality of care and treatment at this hospital. We rated it as inadequate because:

- The service did not have enough nurses and healthcare assistants on the wards. We saw evidence that shifts did not always operate with sufficient numbers of staff to keep patients and staff safe. Staff were often moved between wards to cover other wards. There are other instances where staffing levels fell short of the required numbers for other wards which are included throughout this report.
- Staff sickness absence within the long stay and rehabilitation wards was an average of 7.28%. This figure was higher than normal due to absences associated with the COVID-19 pandemic such as staff needing to self-isolate if they or their loved ones had symptoms or to shield because of underlying medical conditions. There were also 16 staff who had been on long term sickness absence for other medical conditions. However, the provider originally reported that the figure was 46%.
- The wards relied on agency and bank staff to meet the needs of patients. Agency staff were not able to carry out physical interventions except in emergency situations, which meant there were not always enough staff on the wards to participate in required interventions.
- Agency healthcare assistants did not always have the communication skills needed to meet the needs of patients. Patients on Hazelwood, a long stay/ rehabilitation ward, told us that language barriers made it difficult for them to build rapport and trust with these staff members. Managers were already aware of this issue but had not addressed it at the time of our inspection.
- Agency staff did not receive supervision and were unable to carry out physical interventions except in emergency situations, due to not being trained by the provider in the prevention and management of violence and aggression.
- Patient observation charts were not signed in accordance with the provider's observation and engagement policy. Staff members observed patients for long periods of time without breaks which was not in line with the provider's observation and engagement policy.
- Governance structures within the hospital were not consistent in identifying areas of concern and improvement. For example, they did not highlight that observation charts were not signed in accordance with the provider's observation and engagement policy or

Summary of findings

that there was a haphazard approach to ensuring the ward was sufficiently staffed. Poor documentation made it difficult to determine when staff had been on duty.

- Not all the staff on the ward felt supported by managers. Although staff spoke highly of ward managers, some staff members said they never saw members of the senior management team and one said the relationship between the senior management team and frontline staff was dependent on the personalities concerned.

However, we found the following area of good practice:

- Staff assessed and responded to risk. Risk assessments were comprehensive and risk management plans were updated following incidents on the wards.
- Staff managed medicines safely and carried out patient observations within the frequencies prescribed.

Summary of findings

Contents

Inadequate

The Priory Hospital Middleton St George

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units and Long stay or rehabilitation mental health wards for working-age adults.

Summary of this inspection

Background to The Priory Hospital Middleton St George

The Priory Hospital Middleton St George is a 101-bed hospital that provides 24-hour support seven days a week for people aged 18 years and over with mental health problems, personality disorders or both.

Patient accommodation comprises:

- Birch ward – psychiatric intensive care unit for men (12 beds)
- Chester ward – psychiatric intensive care unit for women (12 beds)
- Dalton ward – locked rehabilitation ward for women (13 beds)
- Hazelwood ward – locked rehabilitation/personality disorders ward for women (13 beds)
- Linden ward – locked rehabilitation ward for men (15 beds)
- Oak ward – acute admission ward for women (15 beds)
- Thoburn ward – acute admission ward for both women and men (22 beds).

The hospital director is the registered manager who has been in post since February 2020.

The hospital is registered with the Care Quality Commission to provide the following regulated activities:

- assessment or medical treatment for people detained under the Mental Health Act 1983
- treatment of disease, disorder or injury.

There have been 11 inspections carried out at the Priory Hospital Middleton St George. The most recent inspection took place in September 2019. This was a focused responsive inspection of the Chester ward which was rated good overall and did not affect the outstanding overall rating for the location which they received following our inspection in September 2018.

Our inspection team

The team that inspected the service comprised four CQC inspectors.

Why we carried out this inspection

We received statutory notifications from the provider which indicated a concerning number of ligature and self-harm incidents on the wards. In May 2020, two patients who had self-harmed and ligatured came to the attention of the local authority's safeguarding adults' team. Strategy meetings were held between the local authority, the provider and the CQC to discuss these two patients. Assurances were given to the CQC and local authority that improvements had been made to the hospital to mitigate the risk of such incidents in the future. However, we continued to receive statutory notifications in relation to self-harm and ligatures which gave cause to question the effectiveness of the improvements made.

We also received anonymous whistleblowing alerts. The themes of these alerts were in relation to staffing numbers on the wards, high level of agency staff usage and, questioning agency staff's skills and competency to do their role. They also indicated there was a culture in which staff felt unsupported by managers and unable to raise concerns.

These issues led to a decision to undertake a focused responsive unannounced inspection of the wards to which the incidences of self-harm, ligatures and whistleblowing concerns related. The wards selected for inspection based on concerns around risk and governance structures were Hazelwood, Oak, Thoburn, Birch and Chester wards.

Linden ward had recently been subject to a Mental Health Act monitoring visit and areas for improvement had already been raised with the provider. Based on intelligence from notifications, there were no concerns

Summary of this inspection

about safety for Dalton ward. Based on these factors and being mindful of the need to avoid unnecessary movement between wards due to the risks associated with transmission of the COVID-19 virus; a decision was made not inspect these two wards. However, we did request data relating to them which we used to form part of our overall judgement of the hospital.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

However, for this focused inspection, we covered specific areas under the safe and well-led key questions only as we had not received any intelligence to question the effectiveness of the other three.

Before the inspection visit, we reviewed information that we held about the location and asked for information from the provider around the concerns we had.

During the inspection visit, the inspection team:

- visited five wards at the hospital
- spoke with the hospital director
- spoke with ten patients who were using the service
- spoke with the ward manager of Hazelwood ward
- spoke with six agency healthcare assistants, a bank healthcare assistant, two agency nurses, three permanent nurses, two clinical team leads and 11 permanent healthcare assistants
- looked at 15 patient care records to assess if risk assessments and risk management plans were in place, up to date and addressed any risks identified
- looked at the appropriateness of the use of clozapine and other antipsychotic medicines for ten patients on the wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with five patients on Hazelwood ward during our inspection. They told us that staff were not always available to help them, particularly on night shifts.

There were also mixed views about how regularly they had one to one time with named nurses. One patient had regular time with their named nurse. A second patient normally had daily one to ones but there had been times the nurse had been unavailable. A third patient said they had a handful of one to ones with their nurse but felt more would be helpful. A fourth had spent no time with their named nurse and the fifth said they had regular fortnightly one to ones with their named nurse. Two patients we spoke with told us that they had weekly one to one time, rather than daily, one patient told us they had not had any one to one time in the two weeks prior to our inspection and the other two told us that it was 'hit and miss' and depended on how busy staff were. However, all the patients we spoke with told us that staff were nice and they were well cared for.

Agency healthcare assistants did not always have the communication skills needed to meet the needs of patients. Patients on Hazelwood ward told us that language barriers made it difficult for them to build rapport and trust with these staff members.

We spoke with five patients on the acute and psychiatric intensive care unit wards. Three patients told us that night staff were very busy and seemed to be overstretched. We were told staff did not always have the time to help them.

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?

Inadequate 

Our rating of this service went down. We rated it as inadequate because:

- The service did not have enough nurses and healthcare assistants on the wards. We saw evidence that shifts did not always operate with sufficient numbers of staff to keep patients and staff safe. Staff were often moved between wards to cover other wards. There are other instances where staffing levels fell short of the required numbers for other wards which are included throughout this report.
- The wards relied on agency and bank staff to meet the needs of patients. Agency staff were not able to carry out physical interventions except in emergency situations, which meant there were not always enough staff on the wards to participate in required interventions.
- Staff sickness absence within the long stay and rehabilitation wards was an average of 7.28%. This figure was higher than normal due to absences associated with the COVID-19 pandemic such as staff needing to self-isolate if they or their loved ones had symptoms or to shield because of underlying medical conditions. There were also 16 staff who had been on long term sickness absence for other medical conditions. However, the provider originally reported that the figure was 46%.
- Observation charts were not completed and signed in accordance with the provider's observation and engagement policy. Staff members were placed on observations for long periods of time without breaks which was not in line with the National Institute for Health and Care Excellence guidance.
- An agency staff member on Hazelwood did not know where the ligature cutters were kept

However, we found the following areas of good practice on the ward:

- Staff assessed and responded to risks to patients and themselves. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- The service used systems and processes to safely prescribe antipsychotic medicines. Staff regularly reviewed the effects of these medicines on each patient's physical health.

Summary of this inspection

Are services well-led?

Inadequate 

Our rating of this service went down. We rated it as inadequate because:

- Governance structures within the hospital were not consistent in identifying areas of concern and improvement. Managers did not ensure staff were compliant with the provider's policy for safe observations of patients. Observation forms were not completed correctly, and staff undertook length periods of enhanced observations without a change in activity.
- Documentation on all wards was poor in relation to staffing. We looked at rosters for shifts the month prior to our inspection can found they were illegible. Managers could not provide clarity on staffing numbers during the inspection. This meant we could not determine how many staff had worked on shifts. We were told by the hospital director that on some occasions, this issue had led to staff members not being paid for shifts they had worked.
- Agency healthcare assistants did not receive supervision. They were not trained in provider prevention and management of violence and aggression policy and as such, were unable to carry out restraint on the wards except in emergency situations. Agency staff did not always receive feedback following incidents.
- Not all the staff on the wards felt supported by managers. Although staff spoke highly of the ward managers, some staff members said they never saw members of the senior management team and one said the relationship between the senior management team and frontline staff was dependent on the personalities concerned.
- One staff member did not know how to access the whistleblowing policy.

Detailed findings from this inspection

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

Inadequate

Safe	Inadequate
Well-led	Inadequate

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

Inadequate

Safe staffing

The service did not have enough appropriately skilled nursing staff, who knew the patients to keep patients safe from avoidable harm. The hospital block booked agency members of staff and also had eight registered nurses on its bank staff register.

- Establishment levels: registered nurses (WTE) Thoburn – 12.8, Oak – 8, Birch – 8, Chester – 9.
- Establishment levels: healthcare assistants or equivalent (WTE) Thoburn – 31, Oak – 18.8, Birch – 32.4, Chester – 40.
- Number of vacancies: registered nurses (WTE) – 23 vacancies across the hospital
- Number of vacancies: healthcare assistants or equivalent (WTE) – 35 vacancies across the hospital.
- The number of shifts filled by bank or agency staff to cover sickness, absence or vacancies in 6-month period – Thoburn – 285 registered nurses and 612 healthcare assistants, Oak – 61 registered nurses and 222 healthcare assistants, Birch – 67 registered nurses and 518 healthcare assistants, Chester – 53 registered nurses and 1064 healthcare assistants.
- The number of shifts NOT filled by bank or agency staff where there was sickness, absence or vacancies in 6-month period – Thoburn – 4, Oak – 1, Birch – 0, Chester – 1
- Staff sickness rate (%) in 6-month period – Thoburn – 8.88%, Oak – 3.01%, Birch – 4.67%, Chester – 3.84%
- Staff turnover rate (%) in 6-month period – Thoburn – 6.7%, Oak – 1.5%, Birch – 1.6%, Chester – 5.6%

Staffing levels on the acute and psychiatric intensive care unit wards were assessed using the provider's own staffing ladder. Ward managers told us they were able to adjust the number of staff on shift to take account of the case mix on the ward.

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. The acute and psychiatric intensive care unit services relied heavily on agency and bank staff. Where possible the service used the same staff to ensure they knew the patients and were familiar with the ward. New staff to the ward received a basic induction at the beginning of their shift.

However, due to staff shortages staff were regularly moved between wards. This meant, the number of nurses and healthcare assistants required did not always match the number on all shifts. The wards did not always have an appropriate number of staff to ensure the ward was able to function well.

Following the inspection, we were provided with a spreadsheet giving the required staffing and actual staffing for all the wards for August and September 2020. The spreadsheet showed that on 15 shifts staffing was below the planned safe staffing levels.

On 20 October the provider submitted further information in relation to staffing which stated that all shifts had the required number of staff on duty, on all acute and PICU wards, with the exception of 1 and 2 September when Birch ward had one less healthcare assistant than required.

Records showed that staff were not always taking breaks during shifts. We looked at the staff rosters for 6 August to 26 September and found that 23 registered nurses and healthcare assistants did not get a break during a 12-hour shift. In addition, we found that ten staff between 18 and 23 September, who were with a patient at another hospital did not get a break during their 12-hour shifts.

Not all staff were appropriately trained to carry out physical interventions safely. Patients on psychiatric intensive care unit wards are usually the most unwell and require extra nursing support and high level of enhanced observations.

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

Inadequate

We were informed by staff that agency workers were not allowed to be involved in planned physical interventions. Permanent staff were aware that agency staff could not take part in physical interventions except in emergency situations. We found evidence that an agency staff member had taken part in restraint, which was against the provider's policy which said that agency staff were not to participate in any restraint unless they had been trained by the provider's own training staff or in an emergency situation. Agency healthcare assistants could not carry out restraint, except in emergency situations, because they had not been trained to the provider's standards in the prevention and management of violence and aggression. There was a small response team that could be called if there was an emergency and ward staff needed extra support. However, we had concerns that the lack of trained staff placed both patients and staff at risk of harm.

Due to the level of enhanced observations and movement of staff between wards on each shift, it was difficult to determine if there were enough staff to carry out physical interventions. However, we found records showed that on eight shifts there was not enough staff with the appropriate training to carry out physical interventions safely.

The provider submitted further information on 20 October 2020 which stated that there were enough staff trained in physical interventions for all shifts, with the exception of two occasions.

Assessing and managing risk to patients and staff

Despite significant staff shortages on the acute and psychiatric intensive care unit wards, staff worked well to assess and respond to risks to patients and themselves, particularly given patient acuity within the psychiatric intensive care unit wards was high. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Staff did a risk assessment of every patient on admission and updated it regularly, including after any incident. We looked at the care records of nine patients and found that in all cases the risk assessment had been updated within two weeks of our inspection. All the risk assessments we looked at were detailed and included risks to mental and physical health.

Staff were aware of and dealt with any specific risk issues. Staff identified and responded to changing risks to, or posed by, patients. Where patients had been involved in incidents, we saw that care records had been updated along with risk assessments and observation levels as needed. Where needed, patients were nursed in seclusion or the enhanced care suite in segregation from others on the ward.

Staff were aware of potential ligature points on the wards. Staff knew the location of ligature cutters and how they should be used if needed.

However, staff did not always follow policies and procedures for the use of observation. We found that observation records were not always completed in line with hospital policy. Staff did not always record their names when completing observation sheets and did not always record observations in line with the provider's Supportive Observation and Engagement Policy. For example, the policy states, 'the recording of observation should be specific and detailed and should avoid generic phrases such as sleeping or in lounge'. However, we found that four of the observation records contained these phrases multiple times.

Guidance from the National Institute for Health and Care Excellence (NG10) stated 'If observation is needed for longer than two hours, ensure the staff member has regular breaks'. However, we saw in daily planners that between 5 September 2020 and 18 September 2020 staff were carrying out continuous observations for periods between two hours and seven hours without breaks.

This practice was unsafe as there were high-risk patients on the ward which meant staff needed to be able to observe them with the utmost diligence and concentration. We were concerned that staff would be unable to sustain the required levels of concentration over such long periods of time which potentially meant opportunities to prevent harm could be missed.

The provider's policy stated a staff member should be relieved from observations for 60 minutes every two hours unless exceptions were agreed locally which again, was not being followed.

On 20 October 2020 the provider submitted information to say that rosters do not clearly identify when staff are taking

breaks and had now rectified. Staff we spoke with confirmed that they did not always get breaks and information received from staff after the inspection confirmed this.

The wards in the service participated in the provider's restrictive interventions reduction programme. We witnessed staff using distraction and de-escalation techniques throughout the inspection to good effect.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff regularly reviewed the effects of medications on each patient's physical health. We looked at the records of seven patients on the acute and psychiatric intensive care unit wards who had been prescribed antipsychotic medicines. There was evidence that a doctor had discussed the rationale and any potential side-effects of antipsychotic medication with the patients and given them a leaflet about the medicine. Blood test were carried out regularly to check for side effects from the medication and the appropriate health checks were taken in line with best practice.

There were mechanisms in place to ensure decisions around the prescribing of medicines was overseen, questioned and that consultants were accountable. These included a monthly peer review process based on the Royal College of Psychiatry peer review platform. This process included discussions around training needs and continuous professional development for doctors within the hospital.

There were weekly educational meetings for doctors where patients' medicines were discussed. These meetings helped to capture prescribing patterns and trends. There were also weekly meetings to discuss medicines for patients classed as being high risk; for example, those at risk of deliberate self-harming or suicidal ideation.

One of the doctors at the hospital chaired three monthly medical advisory committee meetings. The ethos of these meetings was to provide assurance and local governance in relation to the hospital's medical practice and medicines management was one of the standing agenda items for these meetings.

Audits of the hospital's medicines management arrangements were undertaken on a monthly basis by an external pharmacy service. The audits included checks of prescription charts with attention focused on individual medicines prescribed, including antipsychotics prescribing and adherence to national guidelines and best practice.

The audits captured the hospital's prescribing data, such as prescribing patters, errors and costs which were fed back to the provider's medical director for information and oversight. The provider also held regional clinical governance meetings and medicines management was one of the key agenda items.

Reporting incidents and learning from when things go wrong

We spoke with four registered nurses and 13 healthcare assistants, some of whom were agency staff. All of the staff we spoke with were aware of what incidents needed to be reported and the process for reporting them. During our inspection there was an incident on Chester ward which resulted in a patient being taken to the de-escalation suite, but this was not recorded on any of the ward paperwork and had not been recorded as an incident on the hospital's incident reporting system.

Staff did not always receive feedback from investigation of incidents. Staff we spoke with told us that if there was a serious incident a Team Incident Review would be carried out and they would receive feedback following this. However, agency staff did not always receive this feedback. Less serious incidents which did not require a Team Incident Review were usually reported during shift handover or team meetings. However, staff told us that handovers were brief and there was not always a lot of information given during these. Agency staff told us they were not invited to team meetings and so did not always receive feedback.

Staff did not always meet to discuss feedback from incidents. Staff we spoke with told us that some incidents were discussed during team meetings but there was not always enough time for this. This meant that staff were not always aware of incidents that had occurred, or lessons learned from incidents.

There was no evidence that changes had been made as a result of feedback. Staff we spoke with told us about a serious incident that had occurred on Birch ward a month prior to our inspection but had not received any feedback from that incident and none of the staff we spoke with was able to tell us of changes that had been made following

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

Inadequate

that or any incident in the service. We reviewed the minutes of the Team Incident Review regarding this incident and found that although there were lessons learned recorded action had not been taken to prevent re-occurrence. For example, at the time of the incident the door to the garden was broken. This had not been repaired at the time of our inspection. There is also a note about staffing and assurances that staff would not be moved from Birch ward if there were shortages on other wards. However, staff were taken from the ward only days after the incident and this continues to be a concern.

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

Inadequate

Leadership

Although leaders were able to give examples to demonstrate they had the skills, knowledge and experience to perform their roles, we were not assured they applied these attributes to proactively identify and address issues across the wards.

Leaders did not have assurance that wards had sufficient numbers of suitably skilled staff to meet patient needs. Staff rostering and shift planning processes were not fit for purpose. Managers could not provide clarity on staffing numbers during the inspection. Managers were aware of the issues with the staff rostering and shift planning processes but had not taken action to address this. The provider could not evidence that staff were taking breaks during shifts. It was not always clear what actions were being taken by leaders within the service in relation to concerns that they had identified.

The hospital director was aware of that the process for recording which staff were at work was problematic and that there was a need to improve the culture within the hospital. However, none of these issues had been addressed at the time of our inspection visit.

The hospital director was aware that agency staff were not able to carry out restraint, except in an emergency situation and acknowledged that this could course difficulties within the service. This issue placed both patients and staff at risk of harm because it meant if patients' behaviours became heightened and they were violent and aggressive, there may be insufficient levels of staff trained in restraint to safely manage the situation. The hospital director advised us that work was underway to provide agency staff with the training needed to ensure this situation was rectified. However, this was not due to be delivered until October 2020.

We spoke with 17 members of staff across the four wards. Some staff told us that they found their respective ward managers were approachable and visible on the ward. However, 14 of those we spoke with told us that they never saw the senior management team. We were told by the hospital director that the senior management team felt restricted in their ability to meet with staff due to the COVID-19 pandemic.

Culture

Some staff told us they felt respected, supported and valued, were able to raise concerns without fear of retribution and felt proud to work within their team and for the provider. However, others said they never saw members of the senior management team and the relationship between the senior management team and frontline staff was dependent on the personalities concerned. We were told by the hospital director that the senior management team felt restricted in their ability to meet with staff due to the Covid epidemic.

Staff who spoke with us said morale and stress levels on Hazelwood were currently good but tended to fluctuate if acuity on the ward was high.

However, the CQC had received concerns from anonymous sources over the last year which alleged that managers did not provide staff with support. In total, 14 whistleblowing concerns were received by the CQC in relation to unsafe staffing levels and experience, staff feeling unsupported and staff being reluctant to speak out because they felt manager would not address the issues concerned.

In May 2020, the provider conducted a whistleblowing investigation in response to the concerns raised. The investigator made a recommendation to explore ways of improving the culture within the hospital to foster better relationships between managers and frontline staff. We asked for an update on what had been done in relation to this recommendation. The hospital director said plans were underway to appoint a freedom to speak up

champion within the hospital to make it easier and more comfortable for staff to raise any concerns they had. She recognised that further work needed to be done to improve the culture. We had concerns that little appeared to have been done in the four months prior to the whistleblowing investigation to address the culture within the service.

Teams worked well together and where there were difficulties, managers dealt with them appropriately.

Governance

The governance structures in place within the service were inconsistent in relation to identifying areas for improvement within the service.

The service was heavily reliant on the use of agency and bank staff and help from permanent staff from other wards to safely meet the needs of its patients.

The processes for recording when staff were on duty and ensuring there were sufficient numbers of staff for each shift were not effective. At the time of inspection documentation was illegible and staffing numbers could not be confirmed. The provider confirmed staffing levels when requested following the inspection, however, then corrected this information in a further submission of evidence.

The provider told us that documentation on the wards was audited to ensure it was completed in line with the provider's policies, processes and expectations. However, the provider had failed to identify from records that staff were carrying out observations for periods of time which were not compliant with the provider's policy for safe observations of patients or that observation forms were not completed correctly. These findings evidenced that the provider's audits were not effective in identifying issues with documentation staff completed on the ward.

We received an email from a complainant claiming that there was a rat in one of the ward's kitchen areas. The provider confirmed that this was due to the hospital being next to a railway embankment which was a breeding ground for rats during the summer months. However, the provider sent us evidence that a pest control company were already taking action to address the issue but this was an ongoing concern.

Staff adhered to the frequency of patient observations in line with those prescribed. Staff knew about the risks associated with the patients they cared for, responded to changes in risk and both risk assessments and risk management plans were of a good quality.

The service's medicines management process was effective and ensured the effects of antipsychotic medicines on patients' physical health was monitored.

The provider told us that documentation on the wards was audited to ensure it was completed in line with the provider's policies, processes and expectations. However, we found staffing rosters were very difficult to read which made determining who had worked on a particular shift problematic. Managers could not provide clarity on staffing numbers during the inspection.

The provider submitted information in relation to staffing rosters however, we were not able to interpret the information and managers could not provide clarity on staffing numbers during the inspection. We asked the provider to clarify the data shown in the rosters and this was provided on 2 October. The provider then submitted further data on 20 October, and we were told that the previous data was incorrect. This shows the provider did not have an effective process in place.

Managers did not ensure staff were compliant with the provider's policy for safe observations of patients. Observation forms were not completed correctly, and staff undertook length periods of enhanced observations without a change in activity. These findings evidenced that the provider's audits were not effective in identifying issues with documentation staff completed on the ward.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Well-led	Inadequate

Are long stay or rehabilitation mental health wards for working-age adults safe?

Inadequate

Safe staffing

The service did not have enough permanent nursing staff to keep people safe from avoidable harm and deliver safe care and treatment. The service was heavily reliant on agency and bank staff and help being provided by permanent staff from other wards to meet the needs of patients. Agency staff did not have the skills required to meet the needs of the patients. The hospital block booked agency members of staff and also had eight registered nurses on its bank staff register.

We asked the provider for data around staffing levels within the service. Their response as at 24 September 2020 gave the following data for the service. The figures supplied were based on a whole time equivalent (WTE):

- Establishment levels of registered nurses – 26 WTE
- Number of registered nurse vacancies - 7.78 WTE
- Establishment levels of healthcare assistants – 68.2 WTE
- Number of healthcare assistant vacancies – 2.37 WTE

These figures were based on a tool used by the provider to calculate the number of staff needed to deliver care and treatment known as staffing ladders. Ward managers were able to adjust the number of staff on shift to meet the needs of the patient group.

A recent recruitment drive had been undertaken and as a result, 18 healthcare assistants were due to start their induction in September and October 2020. Five of these staff members were assigned to work on wards within this service. Managers were experiencing difficulties in recruiting registered nurses to the hospital but had plans to roll out promotion events via open days at the hospital and via social media. In the meantime, the provider's plan was to continue to fill any vacancies via the use of agency and bank staff and overtime.

We asked for data in relation to the use of agency and bank staff used to cover staff absences and vacancies within the service over the last six months. The provider reported as of 30 September 2020:

- 90.5 nurse shifts and 206 healthcare assistant shifts were covered by agency staff.
- 19 nurse shifts and 1,202 healthcare assistant shifts were covered by bank staff.
- 35 shifts were not covered by bank or agency staff.

Staff sickness absence within the long stay and rehabilitation wards was an average of 7.28%. This figure was higher than normal due to absences associated with the COVID-19 pandemic such as staff needing to self-isolate if they or their loved ones had symptoms or to shield because of underlying medical conditions. There were also 16 staff who had been on long term sickness absence for other medical conditions. However, data the provider originally sent in August 2020 showed sickness absence within the service was 46%.

The average staff turnover within the service over the last six months was six per cent.

There were some duties that agency staff were unable to undertake. These included observations for high-risk patients prone to attempting to self-harm by swallowing foreign objects. This was because there had been previous instances in which agency staff had not followed the provider's observation and engagement policy correctly.

Agency staff did not have the skills required to meet the needs of patients. Agency healthcare assistants could not carry out restraint, except in emergency situations, because they had not been trained to the provider's standards in the prevention and management of violence and aggression unless it was an emergency. There was a small response

team that could be called if there was an emergency and ward staff needed extra support. However, we had concerns that the lack of trained staff placed both patients and staff at risk of harm.

The process in relation to staffing on Hazelwood was disorganised and not fit for purpose. There were occasions when agency staff that had not turned up for shift. Staffing rosters were very difficult to interpret due to the number of handwritten amendments. Managers could not provide clarity on staffing numbers during the inspection. We asked the provider to confirm the staffing level on each shift on the staffing rosters. The provider submitted confirmation to us on 2 October 2020 and this information showed that there were frequent shortages in the numbers of permanent staff required for shifts, agency and bank staff were often used and staff were moved to and from different wards to cover shortages within the hospital. There were also occasions when staff shortages were not covered at all. During the period 15 August to 21 September 2020 staffing rosters showed

20 August 2020 (night shift) Linden ward operated with one less healthcare assistant than planned.

5 September (day and night shifts) Linden ward operated both shifts with one less healthcare assistant than planned.

14 September 2020 (night shift) Linden ward operated with one less healthcare assistant than planned.

17 September 2020 (night shift), Linden ward operated with one less registered nurse than planned.

19 August 2020 (night shift), Dalton ward operated with one less healthcare assistant than planned.

The hospital director told us that problems with the way staff on duty were recorded had led to staff not being paid on some occasions.

Shifts were not planned effectively to ensure staff were able to take rest breaks. We looked at daily planners for Hazelwood that were supplied by the provider. These planners showed the tasks assigned to staff members at particular timeslots on shifts. There were two planners for the 6 September 2020 day shift: each including different staff names. This meant we were unable to determine who actually worked on that particular shift. There were also two for the 7 September 2020 night shift with conflicting information around which staff member was carrying out which tasks. We also spoke with two agency healthcare assistants on 20 September 2020 and encountered communication issues due to language barriers. These planners also showed that staff did not always take breaks during 12-hour shifts which was not in line with the UK working time directive which states workers have the right to a 20-minute rest break if they work for six hours or more. During the period 6 September 2020 to 21 September 2020, we planners showed that 16 staff had worked shifts without allocated rest breaks.

We spoke with five patients on Hazelwood. They told us that staff were not always available to help them, particularly on night shifts.

Not all patients on Hazelwood had regular one to one time with their named nurse. One patient told us they had not spent much time with their named nurse. A second had only had a handful of one to ones and said more would be helpful. However, three patients said they had regular one to one time with their named nurse.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff did a risk assessment of every patient on admission and updated them regularly. We looked at seven care records on Hazelwood and noted that risk assessments were being updated regularly, were easy to read and identified the risks associated with each patient. Risks identified were scored as low, medium or high and the scores given were appropriate. Staff used a risk assessment tool built into the provider's care records system. This captured risk in relation to suicide, self-harm, self-neglect, non-adherence with treatment, violence and aggression, risk of absconding, exploitation of and from others, use of drugs and alcohol, physical health, use of the internet and social media and radicalisation.

Staff were aware of the risks associated with the patient group within the service. These included self-harm, ligaturing, swallowing foreign objects, self-neglect, scalding and the need for some patients to be provided with anti-ligature bedding and tear-resistant clothing.

Management of patient risk

Staff were aware of and dealt with any specific issues. Discussions amongst staff evidenced they had a good knowledge of the patients they cared for and what their current presentation and health status was.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff identified and responded to changing risks to, or posed by, patients. Recent ligature incidents on Hazelwood had led to a decision that any patients known to self-harm or ligature were not allowed to wear hooded tops with cords or hair-bobbles. Their rooms and lockers had been searched to remove any risk items such as tin cans that could be used to self-harm.

We spoke with eight ward staff in total and all but one of them were aware of where the ligature cutters were kept, which was in the main office.

Risk management plans were appropriate in addressing the risks identified. We saw evidence that patients at risk of self-harm and ligaturing had been provided anti-rip bedding, patient's mobile devices had to be charged by staff in the office and there were restrictions on their access to areas associated with high risk such as the beverage bar and laundry area.

Staff did not follow good policies and procedures for use of observation. The provider's observation and engagement policy stated a staff member should be relieved from observations for 60 mins every two hours unless exceptions were agreed locally. However, daily planners showed that staff were carrying out observations continuously for periods far in excess of this without breaks. During the period 5 September 2020 to 11 September 2020 we found ten occasions where staff carried out observations continuously for periods of between four and a half hours and six hours.

This practice was unsafe as there were high-risk patients on the ward that were known to swallow foreign objects, ligature and self-harm and as such, which meant staff needed to be able to observe them with the utmost diligence and concentration. We were concerned that staff would be unable to sustain the required levels of concentration over such long periods of time which potentially meant opportunities to prevent harm could be missed.

The provider's observation and engagement policy also stated when handing over observation responsibilities, both staff members must confirm the presentation of the patient together and record this on the observation recording form and when signing the form, the staff member also needed to print their name and designation. We looked at seven observation recording forms on the ward which all evidenced that staff were not fulfilling these requirements. However, we did see evidence that staff were adhering to the frequency of observations prescribed for patients and recording any details of observation and engagement clearly.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff reviewed the effects of antipsychotic medicines on patients' physical health regularly and in line with the National Institute for Health and Care Excellence guidance. We looked at the records for the three patients on Hazelwood who had been prescribed antipsychotic medicines. There was evidence that the ward psychiatrist had discussed the rationale and any potential side-effects with the patient several times and given them a leaflet about the medicine. Bloods were monitored regularly to check for toxicity levels and regular checks of the patient's temperature and oxygen saturation levels were made. Electrocardiograms were also undertaken.

If there were any concerns about the patient's physical health as a result of being prescribed using antipsychotic medicine, staff took the patient to the local acute hospital.

There were mechanisms in place to ensure decisions around the prescribing of medicines were overseen, questioned and that consultants were accountable. These included a monthly peer review process based on the Royal College of Psychiatry peer review platform. This process included discussions around training needs and continuous professional development for doctors within the hospital.

There were weekly educational meetings for doctors where patients' medicines were discussed. These meetings helped to capture prescribing patterns and trends. There were also weekly meetings to discuss medicines for patients classed as being high risk; for example, those at risk of deliberate self-harming or suicidal ideation.

One of the doctors at the hospital chaired three monthly medical advisory committee meetings. The ethos of these meetings was to provide assurance and local governance in relation to the hospital's medical practice and medicines management was one of the standing agenda items.

Audits of the hospital's medicines management arrangements were undertaken on a monthly basis by an

external pharmacy service. The audits included checks of prescription charts with attention focused on individual medicines prescribed, including antipsychotics, prescribing and adherence to national guidelines and best practice.

The audits captured the hospital's prescribing data, such as prescribing patterns, errors and costs which were fed back to the provider's medical director for information and oversight. The provider also held regional clinical governance meetings and medicines management was one of the key agenda items.

Track record on safety

The provider reported as of 5 October 2020 that there had been 12 serious incidents within the service within the last six months: six for Linden ward, four for Hazelwood ward and two for Dalton ward. These related to incidents of violence and aggression, self-harm, ligaturing, a breach of leave conditions and a failure to return from home leave at the agreed time.

There were monthly safety forum meetings held in the hospital. A representative from each ward attended these meetings to feed back any issues around safety that needed to be addressed.

Reporting incidents and learning from when things go wrong

All but one of the frontline staff who spoke with us on Hazelwood understood what incidents needed to be reported and how to report incidents. Incidents reported included self-harm, ligatures, violence and aggression, headbanging, insertion or swallowing of foreign objects, security breaches and financial abuse.

Staff received feedback and lessons learned from investigation of incidents during supervision and appraisal sessions, team meetings, handovers and via email.

There was evidence that changes had been made as a result of incidents within the service. Following instances of patients swallowing foreign objects such as batteries as a result of agency staff not following the observation and engagement policy correctly, a decision had been made that only permanent staff should carry out observations for patients known to self-harm by attempting to ingest items.

Another example of learning from incidents were the changes made in relation to handovers between shifts. The handover template had been updated to ensure all essential information was shared with staff ending and starting shifts. This included patient mood, section 17 leave, medicines, physical health, problem behaviours, risk management strategies, recent incidents, ward round and goals set by the multidisciplinary team meeting and agreed as part of the care programme approach. Staff who spoke with us said they now found the handover to be comprehensive and detailed.

Are long stay or rehabilitation mental health wards for working-age adults well-led?

Inadequate

Leadership

Although leaders were able to give examples to demonstrate they had the skills, knowledge and experience to perform their roles, we were not assured they were able to proactively identify and address issues across the wards.

Leaders did not have assurance that wards had sufficient numbers of suitably skilled staff to meet patient needs. Staff rostering and shift planning processes were not fit for purpose. Managers could not provide clarity on staffing numbers during the inspection. Managers were aware of the issues with the staff rostering and shift planning processes but had not taken action to address this. The provider could not evidence that staff were taking breaks during shifts. It was not always clear what actions were being taken by leaders within the service in relation to concerns that they had identified.

The hospital director, Hazelwood ward manager, clinical lead and a nurse were all aware that agency healthcare assistants did not always have the communications skills to meet the needs of patients due to language barriers which was leading to trust and rapport issues. The hospital director was aware of that the process for recording which staff were at work was problematic and that there was a need to improve the culture within the hospital. However, none of these issues had been addressed at the time of our inspection visit.

The hospital director was aware that agency staff were not able to carry out restraint and acknowledged that this could cause difficulties within the service. This issue placed

both patients and staff at risk of harm because it meant if patients became distressed and they were violent and aggressive, there may be insufficient levels of staff trained in restraint to safely manage the situation. The hospital director advised us that work was underway to provide agency staff with the training needed to ensure this situation was rectified. However, this was not due to be delivered until October 2020.

The senior management team was unaware of issues around staff not correctly signing observation recording forms on Hazelwood.

We spoke with eight members of staff on Hazelwood. Six staff members said they found the ward manager and senior management team were visible and approachable. However, two commented that they never saw the senior management team and did not feel the senior management team understood the issues they had to face every day. We were told by the hospital director that the senior management team felt restricted in their ability to meet with staff due to the COVID-19 pandemic.

Culture

Some staff told us they felt respected, supported and valued, were able to raise concerns without fear of retribution and felt proud to work within their team and for the provider. However, others said they never saw members of the senior management team and the relationship between the senior management team and frontline staff was dependent on the personalities concerned. We were told by the hospital director that the senior management team felt restricted in their ability to meet with staff due to the Covid epidemic.

Staff who spoke with us said morale and stress levels on Hazelwood were currently good but tended to fluctuate if acuity on the ward was high.

However, the CQC had received concerns from anonymous sources over the last year which alleged that managers did not provide staff with support. In total, 14 whistleblowing concerns were received by the CQC in relation to unsafe staffing levels and experience, staff feeling unsupported and staff being reluctant to speak out because they felt manager would not address the issues concerned.

In May 2020, the provider conducted a whistleblowing investigation in response to the concerns raised. The investigator made a recommendation to explore ways of improving the culture within the hospital to foster better relationships between managers and frontline staff. We asked for an update on what had been done in relation to this recommendation. The hospital director said plans were underway to appoint a freedom to speak up champion within the hospital to make it easier and more comfortable for staff to raise any concerns they had. She recognised that further work needed to be done to improve the culture. We had concerns that little appeared to have been done in the four months prior to the whistleblowing investigation to address the culture within the service.

All but one of the staff we spoke with knew how to access the whistleblowing process.

Teams worked well together and where there were difficulties, managers dealt with them appropriately.

Staff sickness absence within the long stay and rehabilitation wards was an average of 7.28%. However, the provider originally reported that the figure was 46%. This figure was higher than normal due to absences associated with the COVID-19 pandemic such as staff needing to self-isolate if they or their loved ones had symptoms or to shield because of underlying medical conditions. The provider did not have a target for staff sickness absence within the hospital but confirmed the North of England Commissioning Support Unit monitored monthly staff sickness absence against a 5% target. The North of England Commissioning Support Unit works across the UK to support health and social care customers in meeting strategic and operational challenges, to improve outcomes and increase efficiency.

Governance

The governance structures in place within the service were inconsistent in relation to identifying areas for improvement within the service.

The service was heavily reliant on the use of agency and bank staff and help from permanent staff from other wards to safely meet the needs of its patients.

The processes for recording when staff were on duty and ensuring there were sufficient numbers of staff for each shift were not effective. At the time of inspection documentation was illegible and staffing numbers could

not be confirmed. The provider confirmed staffing levels when requested following the inspection, however, then corrected this information in a further submission of evidence.

The provider told us that documentation on the wards was audited to ensure it was completed in line with the provider's policies, processes and expectations. However, the provider had failed to identify from records that staff were carrying out observations for periods of time which were not compliant with the provider's policy for safe observations of patients or that observation forms were not completed correctly.

Agency healthcare assistants did not always have the communication skills needed to meet the needs of patients. Patients told us that language barriers made it difficult for them to build rapport and trust with these staff members and was leading to frustration. This problem was exacerbated through the need for the staff members to wear face masks and thus be even more difficult to be understood. We spoke with two agency healthcare assistants where communication was difficult due to English not being their first language. One of these agency healthcare staff gave irrelevant responses to some of our questions despite our rewording them in much simpler way. The ward manager, clinical team lead, a nurse and the hospital director all agreed that this was a known issue, but it had not been addressed at the time of our inspection visit.

Two agency healthcare assistants we spoke with had not received any supervision. Agency healthcare assistants were unable to carry out routine restraint due to not having received training in the prevention and management of violence and aggression.

These findings evidenced that the provider's audits were not effective in identifying issues with documentation staff completed on the ward.

We received an email from a complainant claiming that there was a rat in one of the ward's kitchen areas. The provider confirmed that this was due to the hospital being next to a railway embankment which was a breeding ground for rats during the summer months. However, the provider sent us evidence that a pest control company were already taking action to address the issue but this remained an ongoing concern.

However, lessons learned from investigating incidents were shared with staff so that practice and safety on the wards could be improved.

Staff adhered to the frequency of patient observations in line with those prescribed. Staff knew about the risks associated with the patients they cared for, responded to changes in risk and both risk assessments and risk management plans were of a good quality.

The service's medicines management process was effective and ensured the effects of antipsychotic medicines on patients' physical health was monitored.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there is a robust process to ensure there are sufficient numbers and grades of staff on duty at all times across all wards and that the names and designation of staff are accurately and clearly recorded.
- The provider must ensure that staff adhere to its observation and engagement policy in relation to the length of time staff carry out observations on patients, completion of observation recording forms and breaks are provided in line with the provider's policy.
- The provider must ensure that all agency staff have good communication skills; receive the appropriate training to allow them to meet the needs of patients and receive regular supervision.
- The provider must ensure the governance structures in place within the hospital are consistent and effective in relation to identifying areas for improvement.
- The provider must ensure that an effective audit programme is in place and being carried out, allowing for improvements to be identified and addressed.

Action the provider SHOULD take to improve

- The provider should ensure that all staff know where the ligature cutters are on the wards.
- The provider should ensure that all staff are aware of how to access the provider's whistleblowing policy.
- The provider should ensure that it produces a plan based on the findings of its internal whistleblowing investigation to improve the culture within the hospital and foster better relationships between staff and managers.
- The senior manager team should give consideration to increasing its engagement with staff working on the wards within the hospital to allow staff to ask questions, raise and give feedback should they wish to.
- The provider should ensure that the work intended to address the presence of rats on the wards is carried out as planned and whenever necessary moving forward.
- The provider should ensure that agency staff are informed of any learning from incidents.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Acute and PICU wards for adults of working age** Staffing levels were not always in line with those planned to meet the needs of the patient group. Staffing levels resulted in the wards failing to follow the provider's observation and engagement policy. The policy states a staff member should be relieved from observations for 60 mins every two hours unless exceptions were agreed locally. However, staff were undertaking observations continuously far in excess of this time period which meant this was not being followed. This meant the required levels of concentration and diligence needed to keep patients safe could not be sustained for such long time period. Staff across the wards were not always taking breaks during 12-hour shifts. This contravened the UK working time directive which states that workers are entitled to a 20-minute rest break if they work for more than six hours. Agency healthcare assistants were unable to carry out restraint except in emergency situations, because they were not trained in the use of the provider's prevention and management of violence and aggression policy. They did not receive regular supervision. **These issues were a breach of regulation 12(1)(2)(a)(b)(c)**

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

This section is primarily information for the provider

Requirement notices

Acute and PICU wards for adults of working age.

Documentation in relation to staffing rosters and daily planners was poor and illegible on all wards within the hospital. This meant there were problems in determining which staff had been on duty on shifts, which tasks were assigned to individual staff members and there were potential safety concerns should an evacuation of the wards be necessary given it was not always clear who was on duty.

When asked for information relating to staffing on the wards the provider gave two different sets of figures as they were not able to interpret their own information.

There was a general failure to address concerns on the wards relating to staffing, observation and agency staff not having the required skills and training to deliver their roles.

The provider failed to carry out effective audits to ensure the smooth running of the hospital. For example, staff did not complete observation recording forms in line with the provider's observation and engagement policy. The policy stated that in addition to signing the form, staff should print their name and designation which staff were not adhering to across all five of the hospital wards we inspected. However, this was not identified in any audits.

These issues were a breach of regulation 17 (2) (a) (b)

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Long stay and rehabilitation mental health wards for working-age adults** The service was heavily reliant on bank and agency staff due to vacancies and staff absences on the wards over the six months prior to our inspection. Staff were not always taking their breaks during 12-hour shifts. Staff regularly carried out enhanced observations for long periods of time without breaks and we had concerns that staff were not realistically able sustain the necessary levels of concentration and due diligence required to observe high-risk patients for such long periods. There was a disorganised approach in relation to staffing on Hazelwood ward. Staff made references to agency staff due not turning up for duty and there were telephone calls to other wards about who could be spared staff wise or be released from Hazelwood to help out other wards with staff shortages. Three of the five patients we spoke with on Hazelwood ward told us they did not have regular one to one time with their named nurse. There were communication issues in relation to agency healthcare assistants on Hazelwood ward. Five patients commented that 'agency staff don't know what they are doing' 'some of the staff whose language isn't English it is hard to communicate with and they don't understand mindfulness', 'we get some terrible agency staff', 'there are language barriers quite often', 'sometimes they don't know how the ward works', 'struggling with the amount of unfamiliar faces' and 'it takes long time for me to build up trust so unfamiliar staff can be hard'.

This section is primarily information for the provider

Enforcement actions

The two agency healthcare assistants we spoke with told us that they did not receive supervision, either from their agency or the provider.

Agency staff were unable to carry out routine restraint within the service because they had not received training in the use of the provider's prevention and management of violence and aggression techniques which had the potential to place undue pressure on other ward staff when they needed to restrain patients.

This was a breach of regulation 12 (2) (a) (b) (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 **Long stay and rehabilitation mental health wards for working-age adults** Audits and governance structures within the service were not effective in identifying areas for improvement. The hospital director told us documentation was audited across the wards, however, we found staffing rosters were illegible, information in daily planners was unreliable and observation recording forms were not completed in line with the provider's observation and engagement policy. We also found that daily planners indicated staff undertook enhanced observations for long periods of time without breaks (up to eight and a half hours). This was contrary to the provider's observation and engagement policy which states that colleagues undertaking patient observations should be relieved for 60 minutes every two hours and this had not been picked up as part of auditing processes. Managers were aware of the issues on the wards but had not addressed them. They were aware of communication issues in relation to agency staff; that agency staff were not trained in the provider's prevention and management of violence and aggression techniques and that agency staff were not in receipt of supervision.

This section is primarily information for the provider

Enforcement actions

The was a breach of regulation 17 (1) (2) (a) (b) .