Priory Healthcare Limited

Woodbourne Priory Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

This was a focused inspection. Because of its limited scope, we did not rate any key questions at this inspection. You can view previous ratings and reports on our website at www.cqc.org.uk

- The service did not ensure that the ward had enough suitably qualified staff to meet the needs of all children and young people.
- The service did not ensure that risk assessments were always updated following incidents which indicated a change to risk factors
- The service did not ensure that there was an effective system in place to manage the use of agency staff
- The service did not ensure that staff received adequate support following incidents

However:

- All ward areas were clean, well-furnished, and well maintained.
- Children and young people said they felt safe, and that staff worked hard to meet their needs.
- Staff understood how to protect children and young people from abuse.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to Woodbourne Priory Hospital

Mulberry ward is a mixed gender inpatient child and adolescent ward with 14 beds. Mulberry ward is part of Woodbourne Priory Hospital, it is operated by Priory Healthcare Limited. The majority of children and young people admitted to this ward are detained under the mental health act. At the time of this inspection there were 12 children or young people admitted to the ward.

We carried out this inspection as a result of concerns that had been shared with us by a third party organisation. This was a focussed unannounced inspection which looked at a limited number of key questions.

What people who use the service say

Children and young people told us that they felt safe on the ward and that staff worked hard to meet their needs. They said that they were treated with kindness and compassion and that they were offered the chance to talk following incidents.

Children and young people also told us that the food was not great, that they would like more one-to-one time with their staff and that they would like more activities to be made available to them.

How we carried out this inspection

The team that inspected the service comprised of three CQC inspectors.

During the inspection visit, the inspection team:

- looked at the quality of the environment and observed how staff were caring for young people;
- spoke with six children or young people who were admitted to the service;
- spoke with the senior managers based at or visiting the service;
- spoke with nine other staff members; including support workers, therapists and administrative staff;
- attended meetings specific to client care and the running of the service;
- reviewed closed circuit television recordings;
- looked at five and treatment records of clients: and
- looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Summary of this inspection

- The service must ensure that there are enough suitably trained staff on the ward to safely manage incidents requiring the use of restraint.
- The service must ensure that children's and young people's risk assessments are updated as a result of serious incidents which indicate a change to risk factors.
- The service must ensure that there is an effective system in place to manage agency staff arriving and working at the hospital.
- The service must ensure that staff are adequately supported following incidents.
- The service must ensure that staff are up to date with training in the prevention and management of violence and aggression

Action the service SHOULD take to improve:

- The service should ensure that daily allocations sheets clearly identify who is responsible for carrying out checks in relation to health and safety

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Child and adolescent mental health wards

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Child and adolescent mental health wards safe?

Inspected but not rated

This was a focused inspection. Because of its limited scope, we did not rate safe at this inspection. You can view previous ratings and reports on our website at www.cqc.org.uk.

Safe and clean care environments

The ward was safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated environmental risk assessments of the ward and removed or reduced any risks they identified. However, daily allocation sheets did not always clearly identify who was responsible for carrying out checks in relation to health and safety of the ward, such as who was delegated to carry out environmental security checks or emergency equipment checks. We did not find any evidence that this omission had any impact on patient safety.

Staff could observe children and young people in all parts of the ward and any blind spots were mitigated by risk assessments or additional staffing.

The ward provided mixed sex accommodation, but measures were taken to ensure the privacy and dignity of all children and young people was maintained. Each child or young person had an en-suite bedroom.

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe by individually risk assessing children and young people and providing additional observation where it was necessary.

Staff had easy access to alarms and children and young people had easy access to nurse call systems. During our visit we saw these systems operating effectively.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. There were a number of different lounge areas, a dining room, one to one rooms, an activity room and a separate well equipped classroom.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing. 70% of the permanent staff had carried out infection control training.

Seclusion room

The ward did not have a seclusion room. Very infrequently, approximately once every 6 months, staff had to seclude children and young people in their bedrooms. We looked at a small number of records from when this took place. Records were detailed and it was clear that this was a last resort and that the seclusion ended as soon as it could have. Children and young people were involved in debriefs following these periods of seclusion.

Safe staffing

The service did not have enough substantive nursing and support staff, who knew the children and young people and not all staff working on the ward received mandatory training to keep people safe from avoidable harm.

Nursing and support staff

The service had high numbers of bank and agency support staff, particularly during nights shifts. During the week that we visited the rate of agency staff use on nights shifts ranged from between 63% and 85% out of an average of 12 staff per shift. Over the last three months agency usage was high, 27% for day shifts and 61% for night shifts. However, the need for additional staffing above the wards core numbers was acknowledged due to the high acuity of patients on the ward at the time of our visit

Managers used regular agency staff where possible but there were some occasions when they had to use staff that were new to the hospital and ward.

It was not clear that the service had enough suitably qualified staff on each shift to carry out any physical interventions safely. Although most agency staff had some training in the prevention and management of violence and aggression, they did not all undertake the same training, nor the training specific to the provider. Therefore, there was a risk that techniques could differ and this could lead to restraints being carried out incorrectly or unsafely. Additionally, there was no limit to the number of agency staff that could be on shift at any one time and there was no minimum number of staff that the ward would require to be trained to deal with the prevention and management of violence and aggression. It was unclear how managers were assured that there were enough trained staff on duty at any one time to manage incidents requiring physical intervention safely.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We examined seven recent agency staff inductions, and they were all given the basic information they needed to be able to work on the ward.

The ward manager could adjust staffing levels according to the needs of the children and young people.

Staff shared key information to keep children and young people safe when handing over their care to others. We observed a handover and examined previous handover records. Handovers were detailed and gave staff a useful overview of each patient which included their current risks and how to manage them.

Mandatory training

Staff had completed and kept up-to-date with the majority of mandatory training. However, only 69% of the permanent staff working on the ward were up to date with their training for the prevention and management of violence and aggression.

Managers monitored mandatory training and alerted staff when they needed to update their training, but this system was not always effective. Details about who had done what training was easy to find.

Inspected but not rated

Child and adolescent mental health wards

Assessing and managing risk to children and young people and staff

Staff assessed and managed risks to children, young people and themselves well in most circumstances and 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 but some were not up to date with refresher training.

Assessment of patient risk

We looked at five children's or young people's care records. Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly, including after any incident in all but one of the five records that we looked at.

One patient had been involved in a serious incident that had resulted in them being injured, but the person's risk assessment had not been updated as a result of this incident. This meant that there was potential for staff not to have been aware of this risk. However, we observed the handover where these risks were discussed with staff and when we spoke to staff, they were aware of the risks that each child or young person presented.

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. We spoke to staff about the children and young people that they were working with and they were able to explain the key risk factors for each and they understood how to manage the risks for each patient. We also observed a handover and looked at handover records from previous days. Handovers were detailed and gave staff a useful overview of each patient which included their current risks and how to manage them.

Staff followed procedures to minimise risks where they could not easily observe children and young people. We examined observation charts and they were completed correctly and in line with prescribed recommendations.

Use of restrictive interventions

Levels of restrictive interventions were high at the time of our visit. In the month leading up to our inspection there had been 33 incidents of reported restraint. However, the senior management team explained that a small number of children and young people had needed this level of intervention more often because of how unwell they were. They explained that in one case for example, one of the children and young people would have been moved to a more suitable placement if there was one available.

Not all staff participated in the provider's restrictive interventions reduction programme, but the programme met best practice standards. Only 69% of staff were up to date with this element of mandatory training and because of the large number of agency staff used it was not clear that they were all trained to the same techniques.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young people or others safe. It was clear from the records that we looked at that staff were using restraint as a last resort and the children and young people that we spoke to did not raise any concerns about the levels of restraint or the way it was carried out. We also observed, through review of CCTV footage, incidents being managed positively by staff, with low level holds used only when necessary.

The ward did not have a seclusion suite but when a child or young person was secluded in their bedroom, staff kept clear records which stated that this measure was taken as a last resort, that all items that could be considered a risk were removed from the bedroom and that levels of observation were set accordingly. All bedrooms had a vistamatic window for observations to be made and bathroom access could be limited if the level of risk meant this was necessary. This type of seclusion was only used for short periods of time.

We examined the use of anti-tear clothing on the ward. Anti-tear clothing can be used to minimise the risk of people using their own clothing to harm themselves. Anti-tear clothing was available in a range of sizes that were suitable to children and young people. We only saw one example where it had been used in the previous year. This was clearly documented and was carried out in line with the provider policy. Staff told us that it was used as a last resort and that children and young people usually volunteered to wear it as part of a discussion with staff. Children and young people told us that they knew it was available but that they had never had to make use of it.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. This included all agency staff that worked on the ward.

All staff kept up-to-date with their safeguarding training.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital had a safeguarding lead and specialist social care staff to support other staff where it was required.

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. During the month of August leading up to this inspection there had been a high number of incidents reported. Staff raised concerns and reported incidents and near misses in line with the provider policy.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong. It was clear from incident records that where incidents had occurred that parents were contacted at the earliest opportunity.

Staff told us that managers did not always debrief and support staff after incidents took place. Some staff told us that this meant they left work feeling stressed. However, there was evidence that staff received feedback from investigation of incidents contained within team meeting notes and other documents that staff would be able to access, such as newsletters and there was evidence that staff had access to regular reflective practice sessions.

Inspected but not rated

Child and adolescent mental health wards

Managers investigated serious incidents thoroughly. Children, young people and their families were involved in these investigations. Children and young people told us that they were always consulted with following incidents that involved them.

Staff met to discuss the feedback and look at improvements to patient care. There were examples of discussions in relation to incidents that had taken place and what staff could do differently. Staff records showed that staff were able to attend various types of group supervision sessions that the hospital facilitated.

Are Child and adolescent mental health wards well-led?

Inspected but not rated

This was a focused inspection. Because of its limited scope, we did not rate well-led at this inspection. You can view previous ratings and reports on our website at www.cqc.org.uk.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children, young people, families and staff.

At the time of our visit the ward manager was not present, and the deputy ward manager position was vacant. However, ward managers and deputy ward managers from other wards were spending time on the ward supporting the team.

Culture

Staff did not always feel respected, supported and valued.

Staff told us that they did not receive support following incidents and that they did not always receive regular supervision. Some staff told us that they did not always feel able to voice their concerns about working on the ward.

However, we examined supervision records and they demonstrated that there were several different ways that staff could receive support. Staff had engaged in one-to-one supervision and there was a range of reflective practice sessions and team meetings available for people to access.

Governance

Our findings from the other key questions did not demonstrate that governance processes operated effectively at team level or that performance and risk were managed well.

There were high levels of agency staff use and there was no policy to ensure their identity was checked and confirmed before they entered onto the wards. We saw one new agency staff member walk onto the ward and into a handover and it was not clear who had checked their identification beforehand, although it was checked at the handover. Although agency staff had profiles that were sent to the hospital, it was not clear that this information was routinely shared with the ward staff that were welcoming new agency staff and allocating them to work.

Inspected but not rated

Child and adolescent mental health wards

It was also not clear that the service had enough suitably qualified staff on each shift to carry out any physical interventions safely. Although most agency staff had some training in the prevention and management of violence and aggression, they did not all undertake the same training therefore there was a risk that techniques could differ. Also, the process in place to ensure all staff were up to date with mandatory training was insufficient as only 69% of the permanent staff working on the ward were up to date with training in this area.

Managers had not considered how many staff trained in the prevention and management of violence and aggression were required to be working on the ward at any given time. We were concerned that as there were high numbers of agency staff on duty who may not be trained in the provider's approved and accredited course, managers could not be confident in the numbers of trained staff working on the ward and therefore had not considered what numbers consisted a safe level.

However, we reviewed staff recruitment files and found they were detailed and contained all the necessary documentation to ensure that recruitment was being carried out in a safe way. All staff, including agency, had a current DBS check in place.

We reviewed disciplinary records and they were detailed and contained all the necessary steps to ensure that through investigations were being completed. It was clear that the hospital took necessary and decisive action in cases where allegations had been made against staff, which protected children and young people and staff from potential harm.

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 The service did not ensure that there are enough suitably trained and qualified staff on the ward to safely manage incidents requiring the use of restraint. The service did not ensure that children's and young people's risk assessments are updated as a result of serious incidents which indicate a change to risk factors. The service did not ensure that staff are up to date with training in the prevention and management of violence and aggression.

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 The service did not ensure that there is an effective system in place to manage agency staff arriving and working at the hospital. The service did not ensure that staff are adequately supported following incidents.