Priory Hospital Burgess Hill

Quality Report

Gatehouse Ln
Goddards Green
Hassocks
BN6 9LE
Tel: 01444 231000
Website: www.priorygroup.com/nhs/locations/priory-hospital-burgess-hill

Date of inspection visit: 11 August 2020
Date of publication: 22/10/2020

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

Are services safe?	Requires improvement
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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

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

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

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

Summary of findings

Overall summary

We carried out a focused inspection of two wards at Priory Hospital Burgess Hill. We visited a psychiatric intensive care ward (Elizabeth Anderson) and a forensic low secure inpatient ward (Michael Shepherd). The inspection took place during the COVID-19 pandemic and was unannounced. We focussed on areas of the key question of safe. During the inspection we identified concerns which required us to take enforcement action. Due to this we provided a new rating for safe of requires improvement. However, our overall rating of this service stayed the same.

We found:

• At the time of our inspection 87% of registered nursing posts, and 45% of healthcare assistant positions were unfilled at the hospital. There was high use of agency staff on both wards and patients told us these staff did not always know who they were, or how to meet their needs. This impacted upon the consistency of care available to patients and the hospitals ability to safely manage some risks, such as self-harm.

• Care records across both wards were not sufficiently detailed and did not contain all the required information staff needed to keep patients safe. Seclusion records did not demonstrate that patients were safely observed throughout their time in seclusion.

• Some staff did not understand or follow the hospital's established policies and procedures for managing the environment and patients' safety. Staff did not always follow the hospital's processes and the relevant records were not always properly completed or were inaccurate. This included signing patients in and out for leave and documentation about risk items on the ward, such as crockery.

• Staff did not always complete records of physical health monitoring following use of rapid tranquilisation. Most records showed that one or two attempts had been made to record physical health after the administration of a medicine, but this did not follow the policy of the provider or national recommendation.

• Mental Health Act documentation to authorise treatment was not always available in patients' medicine administration folders. This meant that staff administering medicines would not know if a medicine could legally be given to a patient. Prescribing did not always follow national guidance and the provider lacked a clear process to ensure that this was reviewed and challenged.

However:

• Patients described staff as kind, supportive and respectful.

• The ward environments were clean and well maintained. Staff observed the environment and cameras and mirrors had been installed to reduce the risk blind spots posed. Staff worked towards providing the least restrictive environment possible in order to safely facilitate patients' recovery.

• Patients received regular physical health checks and were able to access a range of specialists when needed. This included access to an annual dental review and other national screening programmes.

Summary of findings

Contents

Priory Hospital Burgess Hill

Services we looked at
Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure wards.

Summary of this inspection

Background to Priory Hospital Burgess Hill

The Priory Hospital Burgess Hill is a purpose-built hospital providing acute and psychiatric intensive care units as well as low secure services and long stay rehabilitation services for people with mental health needs. At the time of inspection, the hospital had five open wards and one closed for refurbishment. These included:

• Elizabeth Anderson, a female psychiatric intensive care unit with 10 beds.

• Amy Johnson, a female specialist personality disorder unit with 10 beds.

• Michael Shepherd, a female low secure unit with 16 beds.

• Wendy Orr, a male psychiatric intensive care unit with eight beds.

• Edith Cavell, a mixed gender acute service with 16 beds.

• Helen Keller was closed for refurbishment.

The hospital last had a comprehensive inspection in April 2019. We rated the service good overall and good in all domains.

The hospital is registered to provide the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury.

There was a registered manager in place at the time of the inspection.

Our inspection team

The team that inspected the service comprised of four CQC hospital inspectors, a medicines inspector, an inspection manager, an expert by experience, and two specialist advisors with experience of working in adult inpatient and low secure settings.

Why we carried out this inspection

We carried out a focussed inspection of Priory Hospital Burgess Hill due to concerns raised in the information we collect about the service and information passed to us from other sources. Since November 2019 we received eight notifications of incidents where staff assigned to observe individual patients had fallen asleep while on duty. We were also told that, in separate incidents, patients had self-harmed using items present within the ward environment. For example, between March and July 2020 five incidents occurred where patients swallowed batteries. We also identified three incidents which raised concerns about the competence of staff administering medicines. A whistle-blower and a member of the public also contacted us to share concerns about the management of a distressed patient and the actions taken by the hospital following a related incident.

How we carried out this inspection

We conducted an unannounced inspection looking at specific areas of the safe key question.

Before the inspection visit, we reviewed information that we held about the location.

Summary of this inspection

During the inspection visit, the inspection team:

• visited two wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients

• spoke with six patients who were using the service

• spoke with the senior leadership team; including the hospital director, director of clinical services, medical director, and governance manager

• spoke with 16 other staff members; including nurses, psychologists and health care support workers

• attended and observed a daily multidisciplinary handover meeting

• looked at 13 care and treatment records of patients

• carried out a specific check of the medicines management for the two wards visited and

• looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients described staff as kind and supportive. Patients felt that care was person-centred and said they were always treated with respect by all members of the multidisciplinary team. However, patients told us there was very high agency use on the wards and there were problems associated with this. For example, patients reported they had been able to bring prohibited items onto the ward as agency staff had not correctly followed the provider's security policies. Patients also reported agency staff did not always know who the patients were. We were given lots of examples where agency staff had completed observations of patients throughout their shift, but towards the end of their shifts had to ask who patients were. This called into question if staff understood patients risks and needs.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

Our rating for safe went down. We rated it as requires improvement because:

- There was high use of agency staff on both wards and patients told us these staff did not always know who they were, or how to meet their needs. This impacted upon the consistency of care available to patients and the hospitals ability to safely manage some risks, such as self-harm.
- Care records across both wards were not sufficiently detailed and did not contain all the required information staff needed to keep patients safe. Seclusion records did not demonstrate that patients were safely observed throughout their time in seclusion.
- Some staff did not understand or follow the hospital's established policies and procedures for managing the environment and patients' safety. Staff did not always follow the hospital's processes and the relevant records were not always properly completed or were inaccurate. This included signing patients in and out for leave and documentation about risk items on the ward, such as crockery.
- Staff did not always complete records of physical health monitoring following use of rapid tranquilisation. Most records showed that one or two attempts had been made to record physical health after the administration of a medicine, but this did not follow the policy of the provider or national recommendation.
- Mental Health Act documentation to authorise treatment was not always available in patients' medicine administration folders. This meant that staff administering medicines would not know if a medicine could legally be given to a patient. Prescribing did not always follow national guidance and the provider lacked a clear process to ensure that this was independently reviewed and challenged.

However:

- Patients described staff as kind, supportive and respectful.
- The ward environments were clean and well maintained. Staff observed the environment and cameras and mirrors had been installed to reduce the risk blind spots posed. Staff worked towards providing the least restrictive environment possible in order to safely facilitate patients' recovery.

Summary of this inspection

- Patients received regular physical health checks and were able to access a range of specialists when needed. This included access to an annual dental review.

Are services effective?
We did not inspect this key question at this time.

Are services caring?
We did not inspect this key question at this time.

Are services responsive?
We did not inspect this key question at this time.

Are services well-led?
We did not inspect this key question at this time.

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

Safe	Requires improvement
Effective	
Caring	
Responsive	
Well-led	

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

Requires improvement

Safe and clean environment

The design of Elizabeth Anderson Ward meant there were several blind spots which hindered observation of patients. However, mirrors were used in these areas to improve lines of sight, and closed-circuit television cameras were also present in all communal areas and bedrooms, which helped to mitigate the risk. Cameras located in bedrooms were physically covered and switched off unless patients had consented to their use. Healthcare professionals employed by an external company monitored the footage and alerted hospital staff to any concerns, who then responded. Staff were present on the ward to monitor the safety of the environment.

Staff were allocated to lead on security each shift. Their role included finding, reporting and addressing any issues with the ward environment. Staff carried out regular environmental risk assessments which were up to date and contained sufficient detail. New staff were shown ligature point risks, blind spots, and other features of the ward environment.

Safety of the ward layout

The ward had fixtures and fittings designed to minimise or remove ligature risk, such as specialist door handles, sanitary ware, bedroom furniture, and curtain rails. A ligature point is anything which could be used to attach a cord, rope or other material for hanging or strangulation. Patient bedroom and bathroom doors were designed to prevent holding, barring and blocking.

Elizabeth Anderson Ward was single sex and all patient bedrooms were en-suite with shower rooms.

Staff carried emergency alarms which, if activated, also notified staff on neighbouring wards. The service recorded tests of the emergency alarm system. Staff were allocated responsibility for responding to emergency alarms on other wards. Staff told us they had at times experienced delays in staff arriving from other wards. However, we did not find evidence of harm occurring as a result of this. Patients had access to alarms to alert staff of an emergency.

Following our last inspection in 2019 we told the provider they should ensure that patients had greater access to the ward gardens and that these spaces should be suitably furnished. At this inspection we found patients had access to a suitably furnished outside space. However, due to the ward being on the first floor, patients required a staff member to access the area. The hospital had explored how to improve garden access for patients but had identified risks which prevented open access. This meant patients had to wait until a staff member was free to help them access the garden.

Maintenance, cleanliness and infection control

Elizabeth Anderson Ward felt welcoming and was in a good state of repair. Artwork was displayed on walls and there was good lighting in place throughout. All furnishings were in good working order and had designs that reduced the risk they posed when patients were distressed. For example, tables and chairs were weighted down and had shapes which made it difficult for them to be thrown, and mattresses and bedroom furniture were designed to resist damage.

Domestic staff were employed by the service and attended the wards daily. During our last inspection we found that some ward areas at the hospital were visibly dirty. We told the provider they should ensure cleaning standards were

maintained and that ward staff were aware of the domestic teams' responsibilities and schedule. At this inspection, we found Elizabeth Anderson ward was clean and tidy. We observed domestic staff working throughout the day to maintain the cleanliness of the environment.

Staff could easily access hand washing basins or alcohol gel. Staff received training in infection control. The service clearly displayed hand washing technique posters at basins. Staff wore face coverings when in clinical areas to reduce the risk of transmission of COVID-19. However, the provider allowed staff to not wear masks while on break, provided they were in designated areas and could maintain social distancing. Visitors were required to wear masks when on site. Patients were supplied with masks, subject to a risk assessment, if they wished to wear them. The service could access COVID-19 testing for staff and patients. Since the beginning of the outbreak only two patients and one member of staff had been diagnosed with COVID-19 at the hospital.

Seclusion room

The ward's seclusion room was occupied when we inspected (seclusion is the supervised confinement of a patient to contain severely disturbed behaviour which is likely to cause harm to themselves or others). Due to privacy, dignity and safety concerns we were unable to physically inspect the seclusion room.

Safe staffing

The hospital struggled to recruit staff and Elizabeth Anderson had a vacancy rate of 88% for registered nurses, and 59% for healthcare assistants. Across the site vacancy rate was 87% for registered nurses and 45% for healthcare assistants. Staff recruitment was on the hospitals risk register. Leaders covered vacant shifts with agency staff. Leaders sought to block book agency staff for longer periods to improve consistency on the ward. However, this was not always possible. This meant that the service had to use ad hoc agency staff on most shifts. While the hospital leadership worked hard to recruit substantive staff, we had concerns about the hospital's heavy reliance upon agency staff to fill vacant shifts, and the ongoing impact of this upon relational security. Relational security is the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care.

The service adjusted staffing numbers based on the complexity of patients' needs. Elizabeth Anderson Ward had a minimum of two registered mental health nurses and two healthcare assistants working in the day. Minimum staffing at night was reduced to two nurses, and one healthcare assistant. When we inspected the ward had 11 staff on duty during the day and night, due to the number of patients on increased levels of observation. We found seven occasions over a four week period where planned staffing numbers were not met. This appeared to be a result of agency workers failing to attend for their shift.

The agreed staffing establishment enabled the ward staff to provide the day-to-day care of patients safely. The service had enough staff to carry out physical interventions and staff had been trained to do so. Staff received training in de-escalation and physical restraint. Managers ensured the hospital had enough appropriately trained staff on shift to safely manage incidents.

The hospital had reported a number of incidents which involved agency staff falling asleep on duty, and agency staff had also been involved in medicines errors. Leaders had investigated these incidents and acted to prevent them reoccurring at the hospital or elsewhere.

The provider had begun to consult staff to identify reasons why staff fell asleep while completing increased patient observations. The hospital now completed welfare checks for staff on increased observations overnight. Leaders also encouraged staff to take steps to stay comfortable and alert while on duty. However, some staff reported that staffing numbers meant they spent long periods observing or supporting patients on a one-to-one basis without a break. This could increase the risk of staff losing focus or falling asleep.

Following the incidents, the hospital had reviewed how they monitored the sign off of substantive and agency staff competence. The hospital already had a process to assess if staff understood hospital policy, procedures and could show their understanding in practice. However, now staff competency checklists were reviewed by leaders whenever there was a change to the rota. Staff who had outstanding competency checklists were not allowed to work at the hospital until these had been completed. The hospital had also recently introduced more robust measures to ensure agency staff who frequently worked at the hospital received regular supervision.

Staff kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. All substantive and bank staff received a two week induction. Agency staff who were block booked to work at the hospital had access to the same mandatory training as substantive staff. Agency staff who worked ad-hoc shifts were required to have undertaken and be up to date with mandatory training before working at the hospital.

Assessing and managing risk to patients and staff

The service completed detailed risk assessments for patients referred to the service and updated inpatients' records regularly. We reviewed five care records all of which identified the relevant risks. Staff updated patients' risk assessments following incidents. Staff described how they supported patients to manage their distress and the strategies they used to de-escalate. Patients attended brief psychological intervention groups which taught skills to manage and tolerate distress. However, four care records lacked detail of how to manage individual patients' distress. This information can support the patient and staff unfamiliar with their needs, helping to avoid or minimise restrictive interventions.

Staff used patient observations to manage patient risk. Staff understood how patient observations could be used to manage environmental risks. The hospital reviewed patients on increased observations daily, and patients who remained on increased observations were subject to an internal and external peer review, where an expert clinician reviewed decision making.

There was an established smoke-free policy at the hospital. Patients could not smoke inside the building or ward gardens. In line with National Institute for Health and Care Excellence (NICE) guidance (PH48) staff provided smoking cessation support and nicotine replacement therapy for patients who wished to receive it. The hospital offered electronic cigarettes to patients. The type of e-cigarette the hospital used had been assessed as being safe for use in high secure settings. Though an individual risk assessment and management plan would still be required. We found that out of a total of 11 ingestion incidents at the hospital in the last six months, five had involved patients swallowing e-cigarette batteries. Leaders were aware of this risk and had been working with staff to reduce further incidents. Staff now issued patches or other forms of nicotine replacement therapy where a patient's risk was too high to use e-cigarettes. However, we were concerned about how consistently the risk was managed on the ward due to the high numbers of agency staff on shifts.

Use of restrictive Interventions

The service gathered information on challenging behaviour, restraint, use of 'as needed' (PRN) medicines and use of rapid tranquilisation. The service sought to identify themes and learn from past incidents. Leaders sought to reduce the usage of PRN medicines and had included this aim on the hospital's improvement plan. The hospital had a staff member on site who specialised in, and who provided training to staff on, the prevention and management of violence and aggression. They supported clinical teams to safely manage patients' risks and to reduce the use of restraint.

Leaders told us they provided debriefs for patients and staff following restrictive interventions and incidents. Staff reported they learnt from past incidents in order to reduce use of restrictive interventions with patients. However, the hospital's records did not provide consistent evidence of debriefs being offered. Staff also told us it was not always possible to hold debriefs, or reflective practice, due to high workload but said support was always available to patients and staff if needed.

Following our last inspection, we told the provider they must ensure that all patients in seclusion received medical reviews according to the hospital policy and the Mental Health Act 1983 Code of Practice. As part of this focused inspection we reviewed two seclusion records, the patients concerned had received medical reviews in line with the necessary requirements. However, we were unable to locate all the relevant nursing records for the period. The Mental Health Act Code of Practice requires that a suitably skilled professional should, as a minimum, be readily available within sight and sound of the seclusion area at all times throughout the patient's period of seclusion. A record of the patient's behaviour should then be made at least every 15 minutes. The two records we reviewed were not complete.

The service avoided use of blanket restrictions. When blanket restrictions were used these were necessary and proportionate. The service assessed the risk posed by personal items or hospital equipment to individual patients.

Staff access to essential information

We found the quality and detail of patients' care and treatment records varied. We reviewed five patient records. All the records we reviewed had care plans and risk assessments present, but the records did not consistently demonstrate the work which appeared to have been undertaken by staff. The hospital had recently updated the electronic system used to store patient care and treatment records. We observed that some staff were not confident using the new records system.

Medicines management

The service used paper prescription charts and an electronic patient record system to support them to prescribe, administer and record the use of medicines. A pharmacist from an external organisation visited weekly to monitor medicines practice and reported to leaders on errors and omissions.

However, we found one example where 'as needed' (PRN) use for a medicine had exceeded the maximum daily dose allowed. This had not been previously found and reported.

Prescribing did not always follow national guidance. The provider lacked guidance to explain to staff what medicines should be used to treat common conditions, although the provider reported this guidance was in development. During the inspection we found clozapine (a medicine for the treatment of schizophrenia) that had been prescribed off-licence (a medicine which is not licensed for treatment of the condition) for the treatment of emotionally unstable personality disorder.

We found repeated one-off use of Clopixol Acuphase; this medicine is usually considered a 'last line' medicine in the management of agitation and aggression. We could not be assured that the prescribing we found had been appropriately independently reviewed to ensure it was in the best interest of the patient and that prescribing followed best practice guidance.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. All medicines were stored safely and securely. Access to medicines was limited to authorised staff only. Staff completed daily checks of the clinic room and fridge temperatures as well as a count of controlled drugs at the change of each shift.

Documents used to record a patient's consent, or the authorisation of treatment under the mental health act (T2 or T3), were kept with the patients' medicine record for staff to review at the point of routine administration. However, two of the seven records reviewed had urgent treatment prescribed which sat outside of these permissions and we did not find a Section 62 with the medicines chart to authorise its use (Section 62 of the Mental Health Act can allow treatment to be given in an emergency as long as it is immediately necessary). Staff should have access to this form prior to administering any medicine not covered on the standard consent to treatment documents. The service reported it had archived the forms after the medicines had been used but it was unable to retrieve them for us to view so we were not assured.

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

The provider had an incident reporting system in place. Staff were able to demonstrate an understanding of recent incidents involving medicines and learnings from these.

PRN medicines and rapid tranquilisation were used frequently on the ward to manage agitation and aggression. Staff told us that rapid tranquilisation use was a last resort if all de-escalation and the offer of oral medicines had been unsuccessful. There were 'calm cards' (a tool to help manage challenging behaviour) in place for some patients on the ward but this had not been widely implemented.

The physical health monitoring that is required after the administration of a medicine for rapid tranquilisation was not fully completed for any of the records we reviewed. Most records showed that one or two attempts had been made to record physical health after the administration of a medicine, but this did not follow the policy of the provider or national recommendations. Rapid tranquillisation is a potentially high-risk intervention that can result in a range of side effects linked to the medication and dose. People given rapid tranquillisation need to be monitored at least every hour until there are no further concerns about their physical status. However, there was physical health

monitoring in place for the use of high dose anti-psychotic treatment. Where patients were prescribed a medicine with stricter monitoring requirements the appropriate checks were completed and recorded in the patient records.

Reporting incidents and learning from when things go wrong

The provider had an incidents policy in place. This covered responding to and reporting incidents. Staff recognised incidents and reported them using an electronic system. Managers investigated incidents and shared lessons learned with the whole team. However, when we cross checked observation records, patient care records and incident reports we found differences in accounts given. For example, the time or duration of an incident. This could impact upon leaders' oversight of incidents and reduce opportunities for learning. We did not find evidence of patients being restrained more frequently, or for longer than was reported.

Managers had acted to address incidents of poor practice which had been reported at the hospital. For example, when an investigation into an agency worker found they had slept while on duty and had been dishonest about this, managers barred them from working at the hospital, and informed the disclosure and barring service.

The hospital sought to learn from inquests and past failings in physical health care. Senior clinicians completed case reviews and had developed and implemented action plans to address any shortcomings.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?
(for example, treatment is effective)

We did not inspect this key question at this time.

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

We did not inspect this key question at this time.

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

We did not inspect this key question at this time.

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

We did not inspect this key question at this time.

Forensic inpatient or secure wards

Safe	Requires improvement
Effective	
Caring	
Responsive	
Well-led	

Are forensic inpatient or secure wards safe?

Requires improvement

Safe and clean environment

The ward environment, although clean, required some cosmetic improvements such as painting and furniture renovations. The provider informed us that there was a program of work scheduled to renovate the ward.

Staff communicated risks through handover meetings and a communications book. Staff told us that handover took place at every shift change. There was also a handover with the multidisciplinary team and senior management team every morning.

Staff observed patients according to their individual observation requirements. Staff completed comprehensive observation records which included detail of the patient's mood and activity. Staff told us that they completed observations at random intervals. However, observation records suggested patient observations were completed on the hour or every quarter of an hour. This could lead to patients accurately predicting when staff will attend to complete observations, providing a window of time in which a patient would be able to harm themselves.

Staff were not allocated to complete observations for one patient for more than two hours. However, staff told us that they often went from one patient's observations to another patient's observations without a break. Completing observations continuously for long periods of time could lead to staff becoming less alert, making mistakes or falling asleep. There had been incidents of staffing falling asleep prior to our inspection. Although the ward had investigated appropriately and taken steps to prevent it happening again, continuous observations were not something that had been addressed.

Staff did not always follow security procedures on the ward. We reviewed the security book for the past two weeks and the crockery counts were not fully completed each day and there were discrepancies between what was recorded and stock levels. The list staff used to know which patients could safely access the kitchen was inaccurate and out of date. There been an incident in the four weeks prior to our inspection involving kitchen crockery resulting in harm to a patient. Patients also told us that agency staff were not aware of the search procedure and had allowed them to take prohibited items onto the ward.

Safe staffing

The ward did not have sufficient numbers of substantive staff. The hospital struggled to recruit staff and Michael Shepherd ward had a vacancy rate of 74% for registered nurses and 36% for healthcare assistants. Across the site this was 87% for registered nurses and 45% for healthcare assistants. There were no unfilled vacancies within the wider multidisciplinary team at the time of the inspection. Vacancies were covered by agency and bank staff. Vacancies included key leadership positions and an agency staff member had been used to fill the ward manager post. In the two weeks prior to our inspection, 46% of healthcare support worker shifts were filled by agency staff and 21% registered nurse shifts were covered by agency. We were told that the establishment figures on night shifts had been adjusted following staffing shortages and now only ran on one registered nurse, instead of the two the provider had previously assessed as required. On the day we inspected, there were two substantive members of staff on the ward and eight were agency staff. Substantive staff told us that although shifts were filled by agency staff, there was a

strong reliance on them by the agency staff to manage complex and distressed patients throughout the shift. Substantive staff said they felt burnt out by this. Agency members of staff told us that the substantive staff were experienced, and this was what made shifts manageable. However, there were no unfilled vacancies within the wider multidisciplinary team at the time of the inspection, except a single social work post, that managers had arranged to be covered by an agency social worker.

Day shifts were nearly always fully staffed, only four percent of day shifts (four shifts in total) in the two weeks prior to our inspection were short by one member of staff and one night shift was short by one member of staff. Staff told us that the hospital had employed someone full time to manage the rotas and ensure the shifts were filled. Previously, the responsibility to ensure shifts were filled would fall to the nurse in charge or ward manager. Staff were positive about this post and reported being rarely short staffed since its implementation.

Agency staff were not appropriately inducted onto the ward prior to the start of their shifts. Patients told us that agency staff had to ask who they were even by the end of their shifts, despite having completed their observations during the shift. Although managers told us that bank and agency staff received a full induction before starting their shift, agency and substantive members of staff told us that the quality of this was variable and was not always in sufficient depth. Substantive ward staff also told us there was a strong reliance on the ward staff to induct agency and bank staff to the ward which placed additional pressures on the substantive ward staff.

Staff completed and kept up to date with their mandatory training. Mandatory training was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. All substantive and bank staff received a two week induction. This included skills workshops where members of staff were required to demonstrate how they would manage challenging situations with patients, such as self-harm. The psychology team reviewed and adapted training for the specific needs of the patient group at the hospital. All staff, including bank and agency, were required to complete competencies around medicines, safeguarding and observations prior to working on the ward.

Staff reported that access to supervision was inconsistent. Some staff reported receiving it regularly and others reported rarely having access to supervision. Compliance records showed that all substantive staff received supervision during July but in the three months prior compliance rates ranged between 78% and 91%.

Assessing and managing risk to patients and staff

Staff assessed risks and recorded these in patients' risk assessments. We reviewed eight patient care records, all of which contained risk assessments. However, two were not up to date and two others had been copied from other patients' records as they contained the wrong patient name. Six of the care records we reviewed did not contain any information on managing the patient's individual distress. This information is particularly important to staff unfamiliar with the patients to allow members of staff to offer support to patients in distress to prevent a crisis. None of the patient records we reviewed contained any information on how to safely restrain each patient, considering risks such as physical health illnesses that could make certain restraints more dangerous.

Psychology staff told us they completed detailed behavioural support plans specifically for patients with challenging and complex behaviour, but that the plans were not routinely completed for all patients. We did not see any examples of these plans in patients' care records, despite persistent challenging and complex behaviour being recorded in some of the patients' records we reviewed.

Psychology and ward staff conducted weekly reflective practice and formulation meetings. The purpose of these meetings was to review how successful behavioural support plans had been and make improvements moving forward. All staff were able to attend, including agency staff. Psychology also facilitated a meeting three times per week between the patients on the ward. This gave patients an opportunity to share if they needed any particular support from their peers. Staff told us this has had a positive impact on the ward environment.

Patients had access to isolation packs if they needed to isolate due to COVID-19. These contained mindfulness exercises, activities and self-help guides on how to manage distress. These received positive feedback from the patients and were consequently rolled out to other hospital sites.

Forensic inpatient or secure wards

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service used paper prescription charts and an electronic system for patient's notes which supported them to safely prescribe, administer and record the use of medicines. A pharmacist from an external organisation came into the service weekly to provide clinical checks and give feedback to the ward on any errors or omissions.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. All medicines were stored safely and securely. Access to medicines was limited to authorised staff only. Staff completed daily checks of the clinic room and fridge temperatures as well as a count of controlled drugs at the change of each shift.

Staff followed current national practice to check patients had the correct medicines. All Mental Health Act documents were kept with the patient's administration records and were available at the point of administration. However, where a medicine was prescribed that was not covered by the current consent to treatment documentation, we did not always see the relevant section 62 form in place to authorise its use. Staff should have access to this form prior to administering any medicine not covered on the standard consent to treatment documents.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The provider had an incident reporting system in place. Staff were able to demonstrate and understanding of recent incidents involving medicines and learnings from these.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. 'As needed' medicines (PRN) and rapid tranquilisation were not used frequently on the ward to manage agitation and aggression. The National Institute for Health and Care Excellence (NICE) defines rapid tranquilisation as 'use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed'. Staff told us that rapid tranquilisation use was a last resort if all de-escalation and the offer of oral medicines had been unsuccessful. Staff told us that after the use of rapid tranquilisation they would sometimes have a debrief to discuss the use of a medicine and try to prevent the need for this type of intervention in future, but this was not always completed. There were 'calm cards' (a tool to help manage challenging behaviour) in place for some patients on the ward but not all.

Staff reviewed the effects of each patient's medication on their physical health according to the National Institute for Health and Care Excellence (NICE) guidance. Physical health was monitored regularly on the ward in line with NICE guidance. The frequency would depend on the needs of the individual patients. There was monitoring in place for the use of high dose anti-psychotic treatment. Where patients were prescribed a medicine with stricter monitoring requirements the appropriate checks were completed and recorded in the patient records. However, the physical health monitoring that is required after the administration of a medicine for rapid tranquilisation was not fully completed for most of the records we reviewed. We reviewed five rapid tranquilisation records, only one was fully completed, four showed that one or two attempts had been made to record physical health after the administration of a medicine, but this did not follow the policy of the provider or national recommendations.

There was additional monitoring in place for medicines that cause constipation and a risk assessment was completed for patients who were prescribed sodium valproate (a medicine usually used for epilepsy or bipolar disorder which has been shown to cause foetal abnormalities and so requires additional precautions in its use).

Reporting incidents and learning from when things go wrong

We reviewed incident reports over the past four weeks. We compared a selection with the patients' observations records and found that there were discrepancies between the details the incident across the two records. This included details such as the times and lengths of restraints and the times of incidents. It was unclear which report was most accurate account. The incident reports contained little detail about the incidents and support given to the patient after the incident.

Management told us that they conducted debriefs with staff after incidents. Staff told us that although they were

Forensic inpatient or secure wards

always offered a debrief, they were normally unable to take place due to workload pressures on the ward. Staff also told us that patients were frequently not debriefed after incidents occurred.

Learning from incidents was not shared across the hospital. Staff told us that feedback from incidents and learning from incidents on other wards was not shared across the staff team. We reviewed team meeting minutes from the past 12 months. Although incidents were discussed at these meetings, only one member of ward staff was present at these meetings on three occasions over the past 12 months.

Are forensic inpatient or secure wards effective?
(for example, treatment is effective)

We did not inspect this key question at this time.

Are forensic inpatient or secure wards caring?

We did not inspect this key question at this time.

Are forensic inpatient or secure wards responsive to people's needs?
(for example, to feedback?)

We did not inspect this key question at this time.

Are forensic inpatient or secure wards well-led?

We did not inspect this key question at this time.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there is a clear system that is followed by all staff for signing patients in and out for section 17 leave (Reg 12).
- The provider must ensure that patients have individualised risk management plans that include safe methods of restraint (Reg 12).
- The provider must ensure that agency staff have an induction onto the ward including a thorough introduction to the patients (Reg 12).
- The provider must ensure that security procedures are followed by all staff working on the ward (Reg 12).
- The provider must ensure that any use of rapid tranquilisation is recorded in line with local policy and national guidance. This includes the recording of physical health monitoring post-administration (Reg 12)
- The provider must ensure that Mental Health Act documents (Section 62) are completed and are easily accessible to staff administering medicines (Reg 11)
- The provider must ensure that seclusion records are maintained to show that patients were observed safely whilst in seclusion (Reg 12)
- The provider must ensure there is a clear process in place to review and challenge prescribing that does not follow national recommendations (Reg 12)
- The provider must continue to work towards recruiting permanent staff to improve consistency of care (Reg 18)

Action the provider SHOULD take to improve

- The provider should ensure that incident records are accurate and consistently maintained.
- The provider should continue to work to ensure observations happen at irregular times so patients cannot predict when they will take place. The provider should also continue to work to ensure staff are not undertaking continuous observations for long periods of time, even if they move between patients.
- The provider should ensure that incident debriefing is consistently offered to all staff and patients involved in incidents and that associated records are maintained.
- The provider should ensure that patient care plans make reference to ways to manage patient's distress and agitation without the need for medicine where appropriate.
- The provider should ensure that all staff have access to regular team meetings and have the opportunity to share learning.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not ensure that Mental Health Act documents (Section 62) were completed and were easily accessible to staff administering medicines This was a breach of regulation 11 (1), (2), & (3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have a clear system for signing patients in and out of leave. The provider did not ensure that security procedures were followed by all staff. The provider did not ensure that patients had individual risk management plans that included safe methods of restraint. The provider did not ensure there was a clear process in place to review and challenge prescribing that did not follow national recommendations. The provider did not ensure that seclusion records were clearly and accurately maintained to show that patients were observed safely whilst in seclusion This was a breach of regulation 12(2)(a)(g)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider did not ensure that agency staff received a thorough induction to the wards or the patients.

The provider did not ensure adequate numbers of permanent staff to allow it to provide consistency of care to patients.

This was a breach of regulation 18(1)(2)(a)