The Priory Ticehurst House

Quality Report

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

Overall summary

On 22 June 2018 we undertook a focussed inspection on Upper Court ward. Concerns had been raised with us about the care and treatment of young people who had been accommodated on Upper Court toward the end of 2017. The concerns related to incidents of young people self harming and an alleged lack of staff skills in responding to these incidents. It was alleged staff were not adequately inducted to undertake their role and as a consequence of this young people were put at risk of harm. As this was not a comprehensive inspection we focussed the inspection on the areas of concern.

We found the following issues the provider needs to improve upon:

- Young people's physical health was not adequately monitored following the use of rapid tranquilisation. Records of the physical health checks were not always completed.
- Records about potential risks for each young person were not always consistent and this could result in them not receiving an appropriate level of observation.
- Permanent and agency staff had not received an induction appropriate to the roles they were to undertake on the ward.
- Records relating to agency staff inductions and staff rotas were poorly maintained.
- Not all staff had received regular supervision.
- The provider did have governance systems in place to monitor and assess the service but where areas needed to improve these were not fully implemented.
- The provider failed to notify CQC of notifiable events concerning the wellbeing of young people.

We found the provider to be in breach of regulation 12, safe care and treatment, regulation 18 staffing and regulation 18 (registration) notification of other incidents.

Summary of findings

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Priory Ticehurst House

Services we looked at
Child and adolescent mental health wards.

Summary of this inspection

Background to The Priory Ticehurst House

The Priory Ticehurst House is situated in East Sussex. It provides inpatient mental health services for adults and young people.

The child and adolescent mental health service at the hospital has two female wards; Garden Court is a tier four ward with 13 beds and Upper Court a high dependency unit with 13 beds for young people.

The hospital also has two acute wards for adults of working age. One ward is a 16 bedded unit for female patients and the other a 9 bedded male ward. There is a four bedded long stay and rehabilitation unit at the hospital.

We undertook this inspection because of concerns about the safety and welfare of young people. During the course of this inspection we focussed on Upper Court.

The Priory Ticehurst House is registered for the following regulated activities: Assessment and medical treatment for persons detained under the Mental Health Act 1983; Diagnostic and screening procedures; Treatment of disease, disorder or injury; Accommodation for persons who require nursing or personal care; Accommodation for persons who require treatment for substance misuse. The hospital has a registered manager in post.

We had previously undertaken an announced inspection on 17 and 18 April 2018 and rated the service 'good' in all domains.

Our inspection team

The team that inspected the service comprised three CQC inspectors.

Why we carried out this inspection

We undertook this focussed inspection following concerns brought to our attention about the care and treatment of young people accommodated on Upper Court toward the end of 2017. The historical concerns related to incidents of young people self harming and staff skills in responding to these incidents. It was alleged staff were not adequately inducted to undertake their role and as a consequence of this young people were put at risk of harm. As this was not a comprehensive inspection we focussed our resources on inspecting the areas of alleged concern.

How we carried out this inspection

As part of our inspection process we considered areas of the service to make a judgement on the following questions:

- Is it safe?
- Is it effective?
- Is it well-led?

'Before the inspection visit, we reviewed information that we held about the location. As this was not a comprehensive inspection, we did not pursue all key lines of enquiry. We focussed only on the concerns raised with us. Subsequently, we have not reconsidered the ratings for this service.

During the inspection visit, the inspection team:

- visited Upper Court and Garden Court wards
- spoke with the registered manager and acting manager for each of the wards

Summary of this inspection

- spoke with seven other staff members; including health care assistants, human resource administrators and agency staff
- looked at seven care and treatment records of patients
- looked at eight staff personnel files
- interviewed four health care assistants
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following issues that the service provider needs to improve:

- Young people did not have their physical health care monitored appropriately after rapid tranquilisation.
- The records of young people's risks were inconsistent. This meant there was a risk that young people might not receive the appropriate level of observation.

Are services effective?

We found the following issues that the service provider needs to improve:

- New permanent staff and agency staff were not adequately inducted into their role.
- Staff had not all received regular supervision.

However

- Robust recruitment processes were in place that helped ensure young people's safety.

Are services well-led?

We found the following issues that the service provider needs to improve:

- The provider failed to notify CQC when required to do so. On four occasions the provider had failed to notify CQC that young people had been admitted to the emergency department of the acute hospital because of incidents of self harm.
- Whilst the provider did have governance systems in place this had not ensured that where improvements were needed that these were fully implemented. For example not all staff had completed inductions or received regular supervisions.
- Some records were poorly maintained such as staff rotas.

Child and adolescent mental health wards

Safe	
Effective	
Well-led	

Are child and adolescent mental health wards safe?

Assessing and managing risk to patients and staff

- The provider did not always protect young people from the risk of harm because there was conflicting information about their assessed levels of risk. We reviewed the risks for seven young people and found on three young people's records there was conflicting information. For example, following an incident of self-harm we saw that staff reassessed the level of risk to the young person and recorded on the young person's progress notes that the risk level had increased. However, the electronic colour coded risk management system was not changed and therefore conflicted with the information recorded on the progress notes. This meant that unless staff read every entry on the progress notes they could easily miss that risks to young people and observation levels had changed.
- Staff had not ensured young people were observed appropriately or that this intervention was effective. One young person who had been on a low level of observation had attempted to self-harm with a ligature. Progress notes showed staff had increased observation levels and yet the incidents of self-harm using a ligature had continued.
- The provider did not always provide the young people with safe care and treatment by ensuring adequate monitoring of their physical health after rapid tranquilisation. We saw three occasions when staff administered rapid tranquilisation injections. We checked the electronic records for each of these young people and found that staff had not monitored and recorded their physical health and wellbeing following administration of the injection.
- Following the inspection, the provider told us that two of these young people had withheld permission for staff to undertake observations and the third consented. Where one young person did consent to their observations being taken, we noted it was over six hours after the administration of the injection. The young person had become unwell, unsteady on their feet and was vomiting, it was at this point observations were undertaken.
- In the event staff were unable to obtain vital observations such as blood pressure or pulse for example, there should be a record of non-contact observations such as respirations, consciousness and pallor so staff can keep young people safe. The National Institute of Health and Care Excellence states "People with mental health problems who are given rapid tranquilisation have side effects, vital signs, hydration level and consciousness monitored after the intervention".

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

Skilled staff to deliver care

- The provider followed a robust recruitment process. We checked files of five recently recruited bank staff or permanent health care assistants on both young people's wards. We saw that the provider undertook all pre-employment checks before commencing an applicant's employment. In the event of any gap in the documents, the provider undertook a risk assessment to decide whether the concern was acceptable or not.
- New staff were not adequately inducted into their role. We reviewed the staff files of three health care assistants who had completed their probationary period and found that the provider did not adhere to its induction process. Areas of the work that were to be covered on the employees first day and first week were not signed off on those days. For example one employee had their

first day of induction signed as completed eight months after they took up post. A second employee's induction form was signed some eight months after their induction period began.

- The provider used high numbers of agency staff to provide care and treatment to young people. On the week of our inspection, a review of the staff rota on the Upper Court showed it took 157 shifts to cover the ward. Agency/locum staff provided 66.7% of these shifts compared to 36.3% of shifts covered by permanent staff.
- New agency staff had not received an adequate induction onto the ward before they began duty. This put young people at risk of poor care. We saw documentation that nine agency staff from the high dependency unit had undergone an induction on 1 June 2018. Seven of these staff had been working shifts the previous week and a further two of those had been working there for several months before this date. This meant the provider was unable to demonstrate the support and guidance these staff received when they started work at the hospital.
- The service employed "locum" staff, who were qualified agency workers working for long periods of time to provide continuity of care. The provider told us these staff accessed training provided to permanent staff. However the provider was unable to show any induction records for these staff working on Upper Court.
- Staff told us they felt supported at work, however this was not evidenced in supervision records we reviewed. Of the twenty permanent health care assistants working on Upper Court, only eight of these had received supervision. Of these, seven had received one to one supervision for the first time on 28 May 2018.

Are child and adolescent mental health wards well-led?

Good governance

- The provider did not maintain an up to date, complete and accurate records on the wards. Records relating to agency staff induction were not filed in any order and locum staff who led shifts had no corresponding agency induction records.
- Staff rotas were a concern in that in many instances they recorded only the first name of temporary workers. This could cause identification problems at a later date if there was an allegation or an incident to investigate.
- We saw that the provider had governance processes in place to identify where improvements were needed. However, these had not been fully implemented for example, staff supervision.
- The provider failed to notify CQC when required to do so. We looked at young people's progress notes and saw that there were four occasions when young people had to attend the emergency department at an acute hospital because they had swallowed an item that could cause them harm. The provider had not notified CQC on any of these four occasions.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that information about young people's risk are consistent across the different recording systems.
- The provider must ensure that young people are appropriately monitored following administration of rapid tranquilisation and records are completed.
- The provider must ensure that clear, accurate and up-to-date records are maintained including staff rotas.
- The provider must ensure all staff receive an induction appropriate to their role before they undertake duties.
- The provider must ensure all staff have regular supervision.
- The provider must ensure that CQC are appropriately informed of all notifiable events.

Action the provider SHOULD take to improve

- Where governance processes identify shortfalls these should be addressed in a timely fashion.

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 risk management system provided conflicting and inaccurate information about the risks to young people and their level of observation.** **Young people did not have their physical health adequately monitored following rapid tranquilisation.** **Young people were not always adequately observed.** **This was a breach of regulation 12(1)(2)(a)(b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not ensure that staff received appropriate induction and supervision to enable them to carry out their duties.** **This was a breach of Regulation 18(1) (2)(a)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Requirement notices

The provider failed to notify CQC of incidents that required treatment of service users.

This is a breach of Regulation 18 (1)(2)(a)(iii)(iv)(b)(ii)