Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Royal Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Gloucestershire Royal Hospital

Inspected but not rated

We found that:

- The gender of the staff undertaking the enhanced observations did not always reflect the gender of the young person.
- There was no privacy in the young persons' rooms, and we were told that de-escalation and restraint took place in the rooms. People moving along the corridor could see into the young person's room.
- Care plans and records did not reflect national guidance for restraint, observation, and emergency sedation.
- Training records showed level 3 safeguarding training was below 50% and not all staff had received training on the mental health needs of children and young persons.
- There were concerns over the competencies of registered nurses supplied by the agency to provide specialist mental health care to the young persons.
- The trust medicines policy and procedures regarding the administration of emergency sedation and the observations of the patient post administration were not being followed.
- Staff were not following the national guidance on the use of emergency sedation in a child or young person. Managers did not have a comprehensive oversight of the administration of emergency sedation.

Services for children and young people

Inspected but not rated

Children's centre

The children's centre at Gloucestershire Royal Hospital provides inpatient and outpatient care. The in-patient's unit consists of 38 beds including general medical and surgical beds, 4 High Dependency Unit beds, and a 4 bedded oncology unit. There is also a paediatric assessment unit with triage and a 6 bedded observation bay.

We carried out this unannounced focused inspection in response to information of concerns provided by the trust about the safety and quality of the services for children and young persons.

The provider had contacted the CQC with concerns that young people were ready for discharge but were inappropriately placed at the hospital with no clear discharge pathway. We were informed that due to their behaviours, physical restraint was being used, together with the administration of emergency sedation and involuntary detention.

As this was a focused inspection of Gloucester Royal Hospital Children's Centre, we only inspected parts of key questions relating directly to their care in Safe, Effective, Caring and Well led.

Our inspection had a short announcement of the evening before, to enable key staff to meet with us. See the children and young people section for what we found.

How we carried out the inspection

During course of the inspection, we visited the children's ward and the emergency department. We spoke with 20 staff, attended a multidisciplinary case meeting with representatives of the local authority present and reviewed sets of patient records. The young persons were offered the opportunity to speak with the inspectors but declined.

You can find further 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.

Is the service safe?

Inspected but not rated

Assessing and responding to patient risk

Staff completed and updated risk assessments for each young person and removed or minimised risks. Staff identified and quickly acted upon young people at risk of deterioration. However, these care plans lacked detail.

The service had access to the children's mental health liaison team 9-5pm 7 days a week. The local children and young persons' team had daily input into the care of young people. This was confirmed by staff we spoke with and was reflected in the patients notes.

Services for children and young people

Staff completed, or arranged, psychosocial assessments and risk assessments for young people thought to be at risk of self-harm or suicide. The enhanced care notes evidenced assessments and the application of restraint, observation, and the administration of rapid sedation. However, these were not in sufficient detail regarding the inclusion of the young person in decision making about their care in line with the National Institute for Health and Care Excellence (NICE) guidance.

The young person's notes did not provide evidence of de-escalation techniques that were to be used and did not provide clarity about the rationale and circumstances in which 'as required' emergency sedation medication was to be administered.

Plans for care and risk management did not refer to advance statements made by the young person and there was no evidence that the young person had been informed of the main side effects of the medication being used. Plans did not evidence inclusion of the young person's preferences in how their behaviour could be managed and the young person's involvement in post incident reviews could be facilitated.

Ward staff informed us that there was no specific plan for each young person on what to do when de-escalation was required.

Shift changes and handovers included all necessary key information to keep children and young people safe.

We saw evidence of an incident reporting database and the audit of incidents. Staff informed us there was feedback from these incidents and post incidents de brief was recorded in the records seen.

The trust had assessed the young people's environment using a ligature risk assessment tool. The ligature risk assessment stated '4 cubicles on the paediatric ward had been designed to accommodate children who were awaiting or being treated for mental health illnesses/symptoms or were being reviewed. The young people were being nursed in these rooms which we observed, as having two-way doors – to prevent the young persons from locking themselves in. TV units were housed behind plastic screens (no cables were visible), there were no pull cords for lighting or emergency bells, and these had been replaced with push buttons. There were no taps, exposed pipping, pull down curtains or non-break glass. Oxygen/suction tubes had been removed, and a member of staff was always with the young person.

The trust provided evidence of referrals to safeguarding for the young people in their care, with evidence of liaison with the local authority.

The trust had insufficient staff to address the needs of the young people and employed Registered Mental Nurses (RMN) through a Nursing agency to supplement the core ward staff. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Not all staff were trained to safeguarding level 3 for children and young persons. A review of the training records indicated that, as of September 2023, 48% of staff in these areas had received level 3 safeguarding training for children and young persons, which was below trust target of 85%.

The ward manager could adjust staffing levels daily according to the needs of the young people. Young people had been placed on levels of enhanced observation and agency RMNs were employed to facilitate these. The numbers of RMNs on duty fluctuated depending on the needs of the young people and the degree of risk they presented, and this was decided upon by ward managers.

Services for children and young people

Records

Staff did not keep detailed records of the children and young people's care and treatment in line with national guidance. Records were not always clear or comprehensively written.

Care bundles supplied to us did not contain a clear care plan for either of the young people regarding triggers which exacerbated their behaviour and how to de-escalate these. Methods of restraint to be used should the de-escalation be unsuccessful were not clearly detailed. Key information on the circumstances of when and how emergency sedation was to be used if required was not described in the plan. There was no evidence in the care bundles of the young person's involvement in such plans.

Not all records we saw were up to date and contained the required information. We saw 8, 'Use of Force Records', which were completed post incident where physical restraint has been applied. These documents were not fully completed, body maps did not detail injuries to the young person, and there were inconsistencies in recording quality and what data was included. This was not in line with the National Institute for Health and Care Excellence (NICE) National Guidance on Violence and aggression: short term management in mental health, health and community settings and the Mental Health Act Code of Practice. Also, this did not reflect the trust's policy, 'restraint and restrictions from 6 years old', issued September 2023.

Medicines

Staff did not always follow prescribing instructions, local policy or national guidance when administrating medicines although the service had systems and processes to safely prescribe, administer, record medicines.

The use of as required rapid sedation was not given in line with the prescriber's instruction and the management of the patient post administration was not in accordance with local policy and procedure and national guidance.

We reviewed 1 set of patient notes who had received emergency sedation and found that on 2 separate days, staff did not follow the prescribed hourly interval for the administration of emergency sedation. These medicines had been administered through both oral and intramuscular routes.

Incidents when emergency sedation was used were not monitored in line with trust policy and the NICE guidance,' Violence and aggression: short-term management in mental health, health, and community settings. The trust policy for 'Prescribing and administration of emergency sedation by oral medicines or intramuscular injection' requires staff to 'Record the Paediatric Early Warning Score (PEWS) every 30 minutes for at least 4 hours. There were no records to evidence that this had been undertaken. However, this young person was under constant visual observation by the Registered Mental Health Nurses.

Incidents

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

Services for children and young people

Staff knew what incidents to report and how to report them. Staff received feedback from investigation of incidents, both internal and external to the service. The hospital's violence and aggression team explained their role, how they reported the incidents, and the audits which were carried out and how they were informed of the results. We reviewed records of incidents for both young people and there was evidence that this information was referred to a multi-disciplinary and multi-agency team meetings.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidenced-based practice.

Staff did not follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The enhanced care bundle did not reflect the guidance of the 'National Institute for Health Care Excellence, Violence and Aggression: short-term management in mental health, health, and community settings.

Staff spoken with confirmed at handover meetings, staff routinely referred to the psychological and emotional needs of the young persons.

Staff on the children's ward and emergency department had not received training in how to manage self-harm. Staff in the emergency department informed us they had not received training in the management of mental health conditions in children. A review of training records found that 92% of staff had received training in conflict resolution.

The children's ward staff had undertaken some additional specialist training relating to the mental health care needs for young people to provide them with safe and effective care. We saw that there were sufficient ward staff adequately trained in the mental health needs of children and young persons.

We were informed the trust was supported by Registered Mental Nurses (RMN) supplied by a nursing agency, to provide constant observations and, if necessary, mental health interventions. The number of these staff fluctuated depending upon the needs of the young persons and the daily risk assessment carried out by ward staff. These RMNs and the hospital's violence and aggression team, were trained in different techniques for restraint and staff reported that these were not compatible meaning that the 2 groups could not work together when physical restraint was required.

The hospital's violence and support team consisted of 41 staff. Records showed all 41 staff had received training and this had been supplemented with a management of aggression course provided by the local authority. Staff spoken with confirmed they received regular updates and annual refreshers. The nursing agency which supplied the RMNs had arranged for staff to receive their mandatory training and we were provided with 5 sets of records supplied by the agency to the hospital which contained details of the training these RMNs had completed through the agency.

Agency staff undertook an induction program before commencing on the ward. We were shown copies of induction records and spoke with agency staff who confirmed they had undertaken an induction when starting on the ward.

Multidisciplinary working

Services for children and young people

Doctors, nurses, and other healthcare professionals worked together as a team to benefit children, young people, and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss the young people and improve their care.

Staff worked across health care disciplines and with other agencies when required and this was evident in the records of communication with outside agencies.

We attended a daily multi-disciplinary meeting where representatives from the local authority were present. The representatives at the meeting were given an update on the young person's emotional and physical needs and discussed possible routes for discharge.

Staff referred children and young people for mental health assessments and worked closely with the children and young person's team to plan care.

There was no clear admission policy which identified the action to take for children and young people in similar circumstances attending the hospital. We were given examples when the ward staff had refused admission based on clinical assessment, but they had been 'overruled,' by senior clinical staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff supported children, young people, and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

We were shown documentation that confirmed that young people were being detained under legal authority and an advocacy service was available to them.

Is the service caring?

Inspected but not rated

Compassionate care

Staff did not always treat the young persons with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. There was no evidence that the young persons had been provided with a choice of staff gender.

Hospital staff were discreet and responsive when caring for the young people. We were given examples of how ward staff took time to interact with the young people in a respectful and considerate way.

The privacy and dignity of the young people receiving care could sometimes be compromised as the gender of the staff undertaking the enhanced observations was not always the same as the gender of the young person. However, personal care was carried out by a staff member of the same gender.

Services for children and young people

Agency staff did not appear to understand or respect the individual needs of each young person. We observed there were only staff of the opposite gender observing the young people on enhanced observations and were informed by one of these RMN that a RMN of the opposite gender was in the toilet cubicle in the room with the patient with the door open. The patient was clothed.

The bedrooms had no screens to protect the privacy and dignity of the young persons, and we were provided with examples of when agency staff had de-escalated situations and used restraint, without ensuring the privacy of the young person. Staff expressed concerns these incidents were having a traumatic effect on the other vulnerable children and young persons.

We saw a clinical record which raised concerns the hospital was not meeting the needs of the patient. This entry stated that the patient had 'no exercise, no educational access, required a health assessment from the medical team, required dental appointment, required an eye test and the hospital needed to 'explore activities within a safe environment'. The authors recommendations were for review of medications, leisure activities and continued support.

Is the service well-led?

Inspected but not rated

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Staff informed us of concerns they had about the performance of the agency staff and gave several examples of poor practice. Staff told us that the agency staff were usually of the opposite gender to the young persons, and that they were not involved in the personal care of the young person.

On our visit, the agency staff observing the young people were seen to be using their mobile phones, not interacting with the patients.

We were shown correspondence between the trust and the nursing agency highlighting concerns about individual staff and detailing actions that were to be taken to address the concerns, including stopping a nurse from working at the hospital in the future.

The trust showed us plans that they had to manage future situations. These included a review of record keeping, the introduction of new paperwork and the involvement of a children's charity to support the young persons and ward staff. There were also plans to recruit 3 youth workers as part of an integrated care board pilot to work with 11–16-year-old children and young people on the children's ward who presented with psychosocial behavioural and mental health conditions. These staff would then follow up the young person post discharge to ensure consistency during the transition stage.

Services for children and young people

Areas for improvement

Action the trust 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 trust MUST take to improve:

Gloucestershire Royal Hospital- Services for Children and young people:

- The trust must ensure that the intercollegiate guidance for safeguarding children and young people on safeguarding training is followed regarding staff training. (Regulation 13(2)).
- The trust must ensure that staff follow trust policies and procedures when administering medications. Regulation 12(2)(g)
- The trust must ensure steps are taken to protect the privacy and dignity of children and young people in their care. Regulation 10(1)

Action the trust SHOULD take to improve:

- The trust should ensure when observations are being undertaken, the gender of the staff observing should reflect the preferences of the young person. Regulation 10(1)
- The trust should ensure care plans reflect national guidance for restraint, observation, and emergency sedation. Regulation 12(1)
- The trust should ensure all staff involved in the management of violence and aggression receive training on how to complete patient records. This should include what information is required to be documented following restraint and use of rapid sedation as detailed in the Nice Guidance for Violence and Aggression: short-term management in mental health, health and community settings and the Mental Health Act Code of Practice 26 Safe and therapeutic response to disturbed behaviour (Regulation 13(4))
- The trust should ensure that the young person is involved, wherever possible, in the planning of their risk management plan, considering any advanced statements by the young person, and that the young person is involved in the post incident debrief. Regulation 12(1)

Our inspection team

The team that inspected the service comprised a CQC Lead Inspector, a second CQC Inspector and an Operations Manager. The inspection team was overseen by Catherine Campbell Deputy Director of Operations.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect