Partnerships in Care Limited

Priory Hospital East Midlands

Inspection report

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Date of inspection visit: 01 September and 07 September 2021
Date of publication: 17/12/2021

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	Requires Improvement
Are services safe?	Inadequate

Summary of findings

Overall summary

Priory Hospital East Midlands provides care and treatment on wards for adults of working age and psychiatric intensive care units for females. It also provides forensic inpatient/secure wards for females.

We inspected specific parts of the safe key questions across all three wards to check that patients were being cared for safely. Because of this, we have only re-rated the safe domain.

We served three warning notices under Section 29 of the Health and Social Care Act 2008 against the provider. We told the provider it was failing to comply with the following Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe care, and treatment, Regulation 15 Premises and equipment and Regulation 17 Good governance.

We told the provider it must become compliant with the regulations by 1 November 2021. The provider told us the action they are taking to make the required improvements and we will continue to monitor this.

We rated Priory Hospital East Midlands as requires improvement because:

- Managers did not ensure the wards were clean and fit for purpose. All three wards were very dirty, the furniture across all the wards was dirty and some items were damaged.
- We found environmental and maintenance issues across all three wards that had not been addressed to ensure the premises were safe and fit for purpose.
- We saw unsafe flooring on Harris ward. We saw a patient had a walking aid who struggled to use the aid on the carpet.
- We found raised metal door hinges on the floor in the bedroom areas on Littlemore Ward, which could have been a trip or self-harm hazard. The kitchen fridge was untidy, dirty and food was not labelled and a bedroom had not been cleaned to remove bodily fluids. There was no access to a communal bathroom for patients.
- The garden steps on Barton ward were unsafe and this posed a potential trip hazard and could also have been used to cause harm or injury.
- Managers did not ensure that the hospital was clean and that they were safely managing Infection Prevention & Control.
- Staff did not safely or effectively manage risks relating to contraband security. On Barton ward the security log was not reflective of what was stored in patients' lockers.
- Managers did not ensure that they reviewed the use of blanket restrictions regularly and adopted a least restrictive approach.
- Staff did not always ensure that patients physical health had been monitored after receiving rapid tranquilisation.
- Managers did not have an effective system in place to ensure that patients' who require long-term segregation are cared for in an environment that meets their needs and reflects their preferences, or in line with the Mental Health Act Code of Practice.
- Staff did not always get the time they required to read patients care plans or review updates to the patients risks.
- Medicines records were not complete and did not contain details on dose, when patients received them.

However:

- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.

Summary of findings

- The wards had enough nurses and doctors and followed good practice with respect to safeguarding.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal.
- The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Inadequate 	Our rating of this service went down. We rated it as inadequate because: The service did not provide safe care. The ward environment was not safe and clean. Staff did not always assess and manage environmental risks well. The carpet and flooring on Harris ward was unsafe and was a risk to patients. The service did not ensure infection control risks were minimised, the wards were not clean. Staff told us did not get the time they required to read patients care plans or review updates to the patients risks. However: Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. The wards had enough nurses and doctors. They minimised the use of restrictive practices and followed good practice with respect to safeguarding. The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare. Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
Acute wards for adults of working age and psychiatric intensive care units	Inadequate 	Our rating of this service went down. We rated it as inadequate because: The service did not always provide safe care. The ward environments were not always safe and clean. Staff did not always assess and manage environmental risks well. The service did not ensure infection control risks were minimised, the wards were not clean. On Littlemore ward we found food that was not labelled clearly in the fridge, stating when it had been

Summary of findings

opened and when it should be consumed by, also the paint on the kitchen servery hatch had peeled and cracked. The clinic room door had peeled paint leaving bare wood, which was dirty and could not be cleaned properly. We found bodily fluids on the wall in a bedroom.

On Littlemore ward there were trip hazards, these were raised metal door hinges on the floor in the bedroom areas. There was no access to a communal bathroom for patients due to ongoing maintenance work.

On Barton ward there was a large piece of skirting board missing in the kitchen. The garden steps were unsafe, one of the steps was broken.

Staff did not always follow National Institute for Health and Care Excellence guidance when using rapid tranquilisation. They did not always carry out physical health monitoring following the administration of rapid tranquilisation.

Staff did not always protect the privacy and dignity of a patient in long-term seclusion.

Staff did not safely or effectively manage risks relating to contraband security on Barton ward.

Managers did not have an effective system in place to ensure that patients' who require long-term segregation are cared for in an environment that meets their needs and reflects their preferences, or in line with the Mental Health Act Code of Practice.

Staff did not get the time they required to read patients care plans or review updates to the patients risks.

Staff did not always follow safe procedures when administering medicines. They did not always ensure they signed when patients had received their medicines.

However:

Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment.

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards.

Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

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Summary of this inspection

Background to Priory Hospital East Midlands

The CQC became aware of an increase in incidents and complaints of low staffing numbers. This was a focused inspection across all three wards of the safe domain.

The following services and wards were visited on this inspection:

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

Littlemore Ward, a female psychiatric intensive care unit with ten beds.

Barton Ward, an acute admission ward for females with nine beds.

Forensic inpatient/secure wards:

Harris Ward, a low female secure ward with nine beds.

The service has a registered manager.

The location offers a specialised assessment and treatment service to help prepare patients for return to either local services or alternative appropriate accommodation. All bedrooms have private en-suite bathrooms. There is a secure garden area for each ward and a gym on site which can be used with staff supervision.

Priory Hospital East Midlands is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.

The last comprehensive inspection of this location was in December 2017. The location was rated as good overall; good for safe, good for effective, good for caring, good for responsive and good for well-led.

What people who use the service say

We spoke with three patients and one carer. Patients' comments were generally positive. One patient told us she felt safe. A patient told us the staff aided their management of anxiety and reduced incidents. However, one patient on Littlemore ward told us they were able to take electric cables from the unlocked meeting room. The electric cable was in an unlocked cupboard and they were able to take back to their room. Two patients said they did not receive a copy of their section 17 leave paperwork. The carer said her relative doesn't get her medication on time or when requested, and staff stopped her from using the office phone. When the carer raised this with the ward staff, she felt they were rude to her.

How we carried out this inspection

The team that inspected the service comprised of three CQC inspectors and one Expert by Experience. Staff, patients, and carers were interviewed by telephone during and after this inspection.

Summary of this inspection

The inspection team visited services and wards between 1 and 7 September and completed further off-site inspection activity. During the inspection we:

Visited the service and observed how staff cared for patients

Toured the clinical environments

Looked at the medicine management on the wards

Spoke with three patients that were using the service

Interviewed six staff including one ward manager, a charge nurse, a doctor, a healthcare assistant, an administrator and a bank healthcare assistant

Interviewed the Hospital Director

Spoke with one carer

Reviewed three staff meeting minutes and one morning meeting

Reviewed nine patient care records

Reviewed 11 observation charts

Reviewed policies and procedures relevant 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 provider 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:

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

The provider must ensure that the environment is well maintained, safe and clean. (Regulation 12 (1) (2) (a) (b) (d))

The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to long term segregation. (Regulation 12 (1) (2) (a) (b))

The provider must ensure that all staff follow infection prevention and control procedures. (Regulation 12 (1) (2) (h))

Summary of this inspection

The provider must ensure that the service reviews the use of blanket restrictions regularly and adopt a least restrictive approach. (Regulation 12 (1) (2) (a) (b))

The provider must ensure effective systems to manage patients in long term segregation. (Regulation 17 2 (a)(b)

The provider must ensure oversight of the cleanliness of the hospital. (Regulation 17,2 (a)(b)

The provider must ensure that they review the use of blanket restrictions regularly and adopt a least restrictive approach. (Regulation 17 2 (a)(b)

The provider must ensure all wards are clean and fit for purpose (Regulation 15,(1)(a)(c)(e)

Action the service SHOULD take to improve:

The provider should ensure the proper and safe management of medicines. (Regulation 12 (1) (2) (g)

Forensic inpatient/secure wards core service:

The provider should ensure that the environment is well maintained, safe and clean. (Regulation 12 (1) (2) (a) (b) (d))

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Inadequate	N/A	N/A	N/A	N/A	Inadequate
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Not inspected	Not inspected	Not inspected	Not inspected	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Not inspected	Requires Improvement

Inadequate

Forensic inpatient or secure wards

Safe	Inadequate
Effective	
Caring	
Responsive	
Well-led	

Are Forensic inpatient or secure wards safe?

Inadequate

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff did not complete or regularly update thorough environmental risk assessments of all ward areas and did not always remove or reduce any risks they identified. Staff completed an environmental checklist daily but did not capture risks that needed escalation. The forms used by staff to record when they completed checks of the environment were basic, lacked space to record any concerns identified and varied across the ward.

We saw unsafe flooring on Harris ward. The carpet from the main ward did not meet with the flooring in the bedroom. Doorways did not have door bars and we saw gaps where the flooring met. In addition, the carpet was frayed and was not stuck down in areas of the main ward. We saw a patient had a walking aid who struggled to use the aid on the carpet.

Staff could observe patients in all parts of the ward.

The ward complied with guidance and there was no mixed sex accommodation.

Staff completed risk assessments to identify ligature anchor points on the ward. A ligature anchor point is something which could be used to attach something else to, which could then cause harm to the person. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients' safe. The mitigation for ligature points, as stated on the risk assessment, was that all patients had individual ligature risk assessments. Closed circuit television cameras were in place throughout the ward and garden. However, this was not continuously monitored.

Staff had easy access to Personal Infrared Transmitter (PIT) alarms and so could summon assistance as and when required. Staff tested alarms regularly. Patients had easy access to nurse call systems in their bedrooms.

Staff followed policy and procedures in line with the current COVID-19 government guidelines. There was adequate supply of hand sanitiser and masks where needed. We observed staff donning and doffing masks, aprons and gloves appropriately.

Inadequate

Forensic inpatient or secure wards

Maintenance, cleanliness and infection control

The ward areas were not clean, well maintained, well-furnished or fit for purpose.

We found environmental and maintenance issues across the ward that had not been addressed to ensure the premises were fit for purpose.

We found the ward was very dirty, there were dead flies in the light fittings, the sealed windowsills of the bedrooms. The furniture was dirty and some items for example, lounge chairs and dining chairs were damaged.

Staff did not make sure cleaning records were up-to-date and the premises were clean. We reviewed cleaning records from 16 August 2021 to 1 September 2021. Out of the 19 hospital cleaning records we reviewed within that period there was missing signatures in 18 of 19 records. In addition, four cleaning records had not been completed at all. This is not in line with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

Managers recruited enough staff in accordance with its staffing ladders. The hospital had an establishment of 14 registered nurses and 43 healthcare assistants. The number of nurses on the wards matched the number the provider had identified should be on the ward in accordance with their 'staffing ladders'.

Levels of sickness across the hospital for August 2021 was 7%. We were told that short term sickness had increased in July and August due to COVID-19 related issues and self-isolation. Managers supported staff who needed time off for ill health.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We saw during this inspection a bank member of staff being inducted to the ward at the beginning of a shift with a comprehensive handover of all patient risks.

The hospital had an average turnover rate of 40%, this had been consistent over a 12-month period.

Managers accurately calculated and reviewed the number and grade of registered nurses and healthcare assistants for each shift. The ward managers could adjust staffing levels according to the needs of the patients.

Inadequate

Forensic inpatient or secure wards

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The wards were supported by an occupational therapist to carry out therapeutic activities.

The ward had enough staff on each shift to carry out any physical interventions safely.

Medical staff

The core service had a consultant psychiatrist and a speciality doctor at the time of our inspection. There was enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to date with their mandatory training which was comprehensive and met the needs of patients and staff.

The manager monitored mandatory training and alerted staff when they needed to update their training. Overall mandatory training across the hospital was 89%.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool. Staff were routinely using the Health of the Nation Outcome Scales (HoNOS) health and social functioning of people with severe mental illness to ensure patients specific needs were met and the Historical Clinical and Risk management assessment tool (HCR20V3) to ensure patients specific needs were met. The multidisciplinary team were all involved in completing patient risk assessments, so all aspects of care and treatment were considered. All care records for patients had up-to-date risk assessments and during ward rounds, staff discussed specific risks to each patient. However, staff did not get the time they required to read patients care plans or review updates to the patients risks. This meant that staff may not be aware of how to identify a deterioration in a patient's mental health, how to support them clinically or as per the patient's wishes, which could put patients and staff at risk of harm.

Staff undertook nursing observations in line with policy and guidelines by the National Institute for Health and Care Excellence.

Inadequate

Forensic inpatient or secure wards

Management of patient risk

During this inspection, we found all patients risk assessments and corresponding risk care plans have been reviewed by the multidisciplinary team. The service had a communication book on the ward for staff.

Staff could observe patients in all areas of the main hospital. All patients had Personal Emergency Evacuation Plans.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Staff followed National Institute for Health and Clinical Excellence guidance when using rapid tranquilisation. Staff had been successful in practices of de-escalation with patients and prevented the need for more invasive interventions. Interventions were well documented, and restrictions had been reduced over time.

Staff had been successful in practices of de-escalation with patients and prevented the need for more invasive interventions. Interventions were well documented, and restrictions had been reduced over time.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Safeguarding

Staff understood how to protect patients 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 knew how to make a safeguarding referral and who to inform if they had concerns. The service had two safeguarding leads. Managers ensured staff compliance with safeguarding training. At the time of the inspection 96% of staff had received safeguarding training.

Staff felt confident to raise safeguarding issues with the senior management team. They knew when they should make referrals to the local authority and which safeguarding concerns to report direct to the regulator. They were aware of risks to children who were part of a patient's family or circle of friends and would take action if concerns were raised about their safety as well.

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

The manager took part in serious case reviews and made changes based on the outcomes and shared this at team meetings.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Inadequate

Forensic inpatient or secure wards

We looked at three patient records, they were electronic format and were comprehensive, and all staff could access them easily. They included up-to-date risk assessments, care plans for mental health and physical health, personal evacuation plans, COVID-19 information. Authorised staff, including bank and agency, could access patient notes.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering and recording medicines. They followed current national practice to check patients had the correct medicines.

Staff regularly reviewed the effects of medicines on each patient's physical health. For example, following the use of rapid tranquilisation. There was an up-to-date stock list with all medicines in date and no excess stock.

The pharmacist gave advice and checked patients' medication, particularly when their prescription changed. Patients and carers said they were encouraged to say when they experienced any problems with their medication.

Decision-making processes ensured that people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff knew which patients were prescribed medication that could lead to addiction. They described how they monitored those patients and what they would do if they saw any signs a patient was becoming dependent.

Track record on safety

The service did not have a good track record on safety.

From 26 April to 8 August 2021 there had been 455 incidents on Harris ward.

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. When things went wrong, staff apologised and gave patients honest information and suitable support.

We were aware of an increase in incidents in the six months leading up to this inspection which staff managed well. Staff ensured that the nature of the incidents was fully recorded, along with the contributing factors and the actions staff needed to take to minimise the risk of reoccurrence.

Staff understood the duty of candour. They gave examples of when they had been open and transparent and gave patients and families a full explanation when things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations as appropriate.

Inadequate

Forensic inpatient or secure wards

Staff received feedback from the investigation of incidents, both internal and external to the service. There was evidence that managers made change as a result of feedback such as COVID- 19 and recent assaults on staff by patients. Staff completed recommendations such as undertaking refresher courses in de-escalation strategies.

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

Inadequate

Safe

Inadequate

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

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

All wards were not safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff did not complete or regularly update thorough environmental risk assessments of all ward areas and did not always remove or reduce any risks they identified. The environmental checklists that staff completed daily did not capture risks that needed escalation. The forms used by staff to record when they completed checks of the environment were basic, lacked space to record any concerns identified and varied across the wards.

We found raised metal door hinges on the floor in the bedroom areas on Littlemore Ward, which could have been a trip or self harm hazard. The garden steps on Barton ward were unsafe, one of the steps was broken, it was not cemented down, and this posed a potential trip hazard risk and could have been used to cause harm or injury. In addition, on the other side of the steps there was only one step, and this was too high which could have resulted in a potential injury. We were concerned that due to these issues patients' could be exposed to avoidable harm.

Staff had not identified or recorded patients access to electrical cables. For example, on Littlemore ward the meeting room cupboard was unlocked and electrical cables easily accessible. A patient told us they could access and remove some electric cable from the cupboard to self-harm. None of these risk concerns found during the inspection had been identified by staff and did not feature on the environmental checklist to guide staff to look for and report any concerns in these areas. Staff we spoke with had not had any specific training or support in identifying clinical risks in the environment.

Staff could observe patients in all parts of the wards.

The wards complied with guidance and there was no mixed sex accommodation.

Staff completed risk assessments to identify ligature anchor points on the wards. A ligature anchor point is something which could be used to attach something else to, which could then cause harm to the person. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients' safe. The mitigation for ligature points, as stated on the risk assessment, was that all patients had individual ligature risk assessments. Closed circuit television cameras were in place throughout the wards, grounds and gardens. However, this was not continuously monitored.

Staff had easy access to Personal Infrared Transmitter (PIT) alarms and so could summon assistance as and when required. Staff tested alarms regularly. Patients had easy access to nurse call systems in their bedrooms.

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

Inadequate

Staff followed policy and procedures in line with the current COVID-19 government guidelines. There was adequate supply of hand sanitiser and masks where needed. We observed staff donning and doffing masks, aprons and gloves appropriately.

Maintenance, cleanliness and infection control

Ward areas were not clean, well maintained, well-furnished and fit for purpose.

We found environmental and maintenance issues across the wards that had not been addressed to ensure the premises were fit for purpose. On Littlemore ward, we found paint on the kitchen servery hatch had peeled and cracked. The wood appeared to be recycled wood from a door frame, which hinges had been removed from, leaving bare wood which was dirty and could not be cleaned effectively. There was no access to a communal bathroom for patients on Littlemore ward, which had been closed off for up to 12 months due to maintenance issues that had not been addressed at the time of this inspection. On Barton ward we found there was a large piece of skirting board missing in the kitchen. These risks had not been identified by staff and had not been raised with the maintenance team to be repaired.

We found both wards were very dirty, there were dead flies in the light fittings, the sealed windowsills of the bedrooms and the seclusion room. The furniture across all the wards was dirty and some items for example, lounge chairs and dining chairs were damaged.

Staff did not make sure cleaning records were up-to-date and the premises were clean. We reviewed cleaning records from 16 August 2021 to 1 September 2021. Out of the 19 hospital cleaning records we reviewed within that period, there was missing signatures in 18 of 19 records. In addition, four cleaning records had not been completed at all. The kitchen fridge on Littlemore ward was untidy, dirty and food was not labelled. We found in bedroom three on Littlemore ward blood up the wall, which had been there for a period of 24 hours. This is not in line with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.

Seclusion room

There was a seclusion room on Littlemore ward. The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. However, staff had not ensured that the room was clean, we found a stain on the floor underneath the mattress which had not been identified by staff. There were no patients in the seclusion room at the time of this inspection.

Clinic room and equipment

The paint on the clinic room door had peeled leaving bare wood, which was dirty and could not be cleaned, and did not allow for the safe dispensing of medication to patients.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

Managers recruited enough staff. The hospital had an establishment of 14 registered nurses and 43 healthcare assistants. The number of nurses on the wards matched the number the provider had identified should be on the ward in accordance with their 'staffing ladders'.

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

Inadequate

Levels of sickness across the hospital for August 2021 was 7%. We were told that short term sickness had increased in July and August due to COVID-19 related issues and self-isolation. Managers supported staff who needed time off for ill health.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The hospital had an average turnover rate of 40%, this had been consistent over a 12-month period.

Managers accurately calculated and reviewed the number and grade of registered nurses and healthcare assistants for each shift. The ward managers could adjust staffing levels according to the needs of the patients.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The wards were supported by an occupational therapist to carry out therapeutic activities.

The wards had enough staff on each shift to carry out any physical interventions safely.

Medical staff

The core service had a regular consultant, an associate specialist and two locum doctors at the time of our inspection. The service had been able to recruit to the advertised posts and a further regular consultant was due to start in eight weeks. There was enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to date with their mandatory training which was comprehensive and met the needs of patients and staff.

The manager monitored mandatory training and alerted staff when they needed to update their training. Overall mandatory training across the hospital was 89%.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well 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 did not participate in the provider's restrictive interventions reduction programme.

Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool. Staff routinely used the Health of the Nation Outcome Scales (HoNOS) health and social functioning of people with severe mental illness to ensure patients specific needs were met. The multidisciplinary team were all involved in completing patient risk assessments, all aspects of care and treatment were considered.

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

Inadequate

Whilst care records for patients had up-to-date risk assessments, staff told us they did not get the time they required to read patients care plans or review updates to the patients risks. This meant that staff may not be aware of how to identify deterioration in a patient's mental health and be able to support them as clinically needed or how the patient wanted, which could put patients and staff at risk of harm.

Staff undertook observations in line with policy and guidelines by the National Institute for Health and Care Excellence. The observations were well documented in the 11 observation charts that we reviewed across the hospital. However, prior to this inspection we received information from the provider telling us that there had been an incident where an agency staff member had fallen asleep whilst on patient observations. The provider took appropriate action to deal with this.

Management of patient risk

Staff did not always know about any risks to each patient and did not always take action to prevent or reduce risks. We found risks with contraband security. On Barton ward the security log was not reflective of what was in patients' lockers. For example, the security log for one patient stated nail varnish, dry shampoo and perfume. When we looked in the locker there was only nail varnish. For another patient the documentation said nothing was in the patient's locker, when we checked it was full of toiletries, a razor and art equipment.

Staff could observe patients in all areas of the main hospital. All patients had Personal Emergency Evacuation Plans.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Staff did not always follow National Institute for Health and Clinical Excellence guidance when using rapid tranquilisation. We found that four patients records did not document monitoring of the patients physical health in line with the guidance. Staff had been successful in practices of de-escalation with patients and prevented the need for more invasive interventions. Interventions were well documented, and restrictions had been reduced over time.

The ward staff did not participate in the provider's restrictive interventions reduction programme. During our inspection, we saw restrictive practice in place. For example, patients were unable to access the garden unsupervised on Barton ward due to previous incidents.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff did not follow best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. During our inspection we saw a patient being cared for in a long-term segregation area. However, this was not a designated long-term segregation suite. The room used was a single room, with no access to outsides space, lounge area, a chair or a place to eat meals. We saw the patient had low stimulus and lack of therapeutic intervention. We found no evidence of improvements to the system for implementing long-term segregation which would ensure that patients were cared for in an environment that reflects their needs and meets their preferences.

Safeguarding

Staff understood how to protect patients 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.

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

Inadequate

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had two safeguarding leads. Managers ensured staff compliance with safeguarding training. At the time of the inspection 96% of staff had received safeguarding training.

Staff felt confident to raise safeguarding issues with the senior management team. They knew when they should make referrals to the local authority and which safeguarding concerns to report direct to the regulator. They were aware of risks to children who were part of a patient's family or circle of friends and would take action if concerns were raised about their safety as well.

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

The manager took part in serious case reviews and made changes based on the outcomes and shared this at team meetings.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

We looked at six patient records, they were electronic format and were comprehensive, and all staff could access them easily. They included up-to-date risk assessments, care plans for mental health and physical health, personal evacuation plans, COVID-19 information. Authorised staff, including bank and agency, could access patient notes.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff did not always follow systems and processes when administering and recording medicines. Medicine records were not always complete and when patients received them. For example, on Barton ward we found two missing signatures on the drugs card for one patient, we could not be assured that the patient had received their medicines.

The pharmacist gave advice and checked patients' medication, particularly when their prescription changed. Patients and carers said they were encouraged to say when they experienced any problems with their medication.

Decision-making processes ensured that people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff knew which patients were prescribed medication that could lead to addiction. They described how they monitored those patients and what they would do if they saw any signs a patient was becoming dependent.

Track record on safety

The service did not have a good track record on safety.

From 26 April to 8 August 2021 there had been 420 incidents on Littlemore ward and 408 incidents on Barton ward.

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

Inadequate

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. When things went wrong, staff apologised and gave patients honest information and suitable support.

We were aware of an increase in incidents in the six months leading up to this inspection which staff managed well. Staff ensured that the nature of the incidents was fully recorded, along with the contributing factors and the actions staff needed to take to minimise the risk of reoccurrence.

Staff understood the duty of candour. They gave examples of when they had been open and transparent and gave patients and families a full explanation when things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations as appropriate.

Staff received feedback from the investigation of incidents, both internal and external to the service. There was evidence that managers made change as a result of feedback such as COVID- 19 and recent assaults on staff by patients. Staff completed recommendations such as undertaking refresher courses in de-escalation strategies.

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 15 HSCA (RA) Regulations 2014 Premises and equipment The provider must ensure all wards are clean and fit for purpose (Regulation 15(1)(a)(c)(e)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that the environment is well maintained, safe and clean. (Regulation 12 (1) (2) (a) (b) (d)) The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to long term segregation. (Regulation 12 (1) (2) (a) (b)) The provider must ensure that all staff follow infection prevention and control procedures. (Regulation 12 (1) (2) (h)) The provider must ensure that the service reviews the use of blanket restrictions regularly and adopt a least restrictive approach. (Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure effective systems to manage patients in long term segregation. (Regulation 17 2 (a)(b) The provider must ensure oversight of the cleanliness of the hospital. (Regulation 17 2 (a)(b)

This section is primarily information for the provider

Requirement notices

The provider must ensure that they review the use of blanket restrictions regularly and adopt a least restrictive approach. (Regulation 17 2 (a)(b)