Woodbourne Priory Hospital

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

Ratings

Overall rating for this location

Are services safe?

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.

Overall summary

We did not rate Woodbourne Priory Hospital following our inspection.

At this inspection we found that:

- Staff did not label topical medications for use on individual patients, therefore risking cross-infection.
- The provider's Rapid tranquilisation policy did not accurately reflect the current NICE guidelines [NG10] Violence and aggression: short-term management in mental health, health and community settings, issued May 2015. The service did not monitor deviation from the guidelines.
- Staff did not have access to guidance which covered individual patients medicines that were being used in the management of violence and aggression.

However:

Summary of findings

- At our last inspection we found that staff had not always completed security checks on Beech Ward. On this inspection, we found that the provider had put in place processes to address the issue and staff on all wards had completed ward security checks as required.
- At our last inspection we found that mandatory safeguarding training completion was low. During this inspection we found average mandatory training rates had increased across all wards and the majority of staff had completed mandatory safeguarding training.
- At our last inspection we found that staff had not always adhered to Priory's policy on standards of dress, uniform and personal appearance. On this inspection, we found ward managers monitored this and completed regular audits of infection control.
- Staff monitored room and medication fridge temperatures and ensured they were kept within a safe range.
- Staffing levels were appropriate across all wards and Aspen Ward had increased from five day staff to six. This meant staff had more time to complete clinical duties and spend time with patients. Staff were always able to facilitate escorted leave.

Summary of findings

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Summary of this inspection

Background to Woodbourne Priory Hospital

Woodbourne Priory Hospital is owned by the Priory Group which merged with Partnerships in Care in November 2016. Woodbourne Priory Hospital is registered to provide care and treatment to children, young people and adults with mental health conditions, including those whose rights are restricted under the Mental Health Act.

The service is registered to provide the following regulated activities:

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

The service can accommodate up to 78 patients and comprises seven wards. Mulberry Ward is a mixed gender inpatient child and adolescent mental health ward with 14 beds. Rowan Ward is a mixed gender high dependency ward for children and adolescents and has eight beds. Oak Ward is a female-only specialist eating disorder ward and has eight beds. Maple and Beech wards are mixed gender acute wards for adults aged 18-25 and have 28 beds. Aspen Ward is a male-only psychiatric intensive care unit for 16-25 year olds and has 10 beds. The Manor is a private adult mental health ward and has 9 beds.

The service has had three Mental Health Act visits in the 12 months before this inspection.The service had a registered manager and an accountable officer for controlled drugs officer.

Our inspection team

Team leader: Maria Lawley, inspector. The team that inspected the service comprised two CQC inspectors and one pharmacy inspector.

Why we carried out this inspection

We undertook this inspection to find out whether Woodbourne Priory Hospital had made improvements to their acute wards for adults of working age and psychiatric intensive care units since our last inspection in June 2017.

Following our inspection in June 2017, we rated Woodbourne Priory Hospital overall rating as 'good'. However, we rated the Safe domain as 'requires improvement'. We told the provider that it must make the following improvements:

- The provider must mitigate risks by ensuring ward security checks are carried out and signed as complete by a responsible individual.
- The provider must ensure staff on Maple, Beech and Aspen wards are adequately trained in safeguarding adults and children to enable them to carry out the duties they are employed to perform and keep patients safe from harm.

We issued requirement notices for the following breaches of regulations:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 18 HSCA (RA) Regulations 2014 Staffing.

Summary of this inspection

How we carried out this inspection

We asked the following question of the service and provider:

- is it safe?

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

During the inspection visit, the inspection team:

- visited all three acute wards for adults of working age and psychiatric intensive care units wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 3 patients who were using the service;
- spoke with the registered manager and managers or acting managers for each of the wards;
- spoke with 10 other staff members; including doctors and nurses;
- looked at 18 care and treatment records of patients;
- carried out a specific check of the medication management on three wards;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

All patients told us the environment was good and kept clean. Patients told us they felt safe and spoke highly of staff and the service. One patient raised concerns about the ratio of female patients to male patients on Maple Ward. They told us there were more males then females and this made them feel uncomfortable.

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 did not rate safe at this inspection.

On this inspection, we found that:

- Staff did not label topical medications for use on individual patients, therefore risking cross-infection.
- The provider's Rapid tranquilisation policy did not accurately reflect the current NICE guidelines [NG10] Violence and aggression: short-term management in mental health, health and community settings, issued May 2015. The service did not monitor deviation from the guidelines.
- Staff did not have access to guidance which covered individual patients medicines that were being used in the management of violence and aggression.

However:

- We found that the provider had put in place processes to address the issue and staff on all wards had completed ward security checks as required.
- Average mandatory training rates had increased across all wards and the majority of staff had completed mandatory safeguarding training.
- Staff adhered to Priory's policy on standards of dress, uniform and personal appearance and ward managers monitored this and completed regular audits of infection control.
- Staff across all wards had improved in completion rates of all areas of mandatory training. This had improved since our previous inspection.

Detailed findings from this inspection

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

Safe

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

Safe and clean environment

- The layout of Maple and Beech wards did not allow staff to observe all parts of the ward. The provider reduced blind spots (an area where people cannot be seen) using observations or supervision, closed-circuit television (CCTV) cameras and wall-mounted dome mirrors. There were some areas on Maple and Beech wards that were not covered by CCTV cameras, for example, the patient courtyard on Beech Ward and the consultant's office on Maple Ward. Staff had highlighted this to the senior management team as a potential risk. Staff took measures to ensure patients were kept safe in these areas using individual patient risk assessments, environmental risk assessments and observations.
- The layout of Aspen Ward allowed staff to observe the communal living area and a quiet lounge from the nurse's office. The corridor where the patients' bedrooms, the gym and the activity room were located was a blind area. There were blind spots in the bedrooms and a blind spot in the seclusion room. Staff reduced blind spots with the use of observations and had installed a domed mirror in the seclusion room to improve visibility.
- Staff completed an annual ligature risk audit for Maple, Beech and Aspen wards. Staff reviewed this regularly and when changes to the environment were made or new equipment was provided. A ligature is something used for tying or binding something tightly and can be used to self-harm. A ligature risk audit is a document that identifies places/objects to which patients intent on self-harm might tie something to strangle themselves. At our last inspection we found that staff had not always completed security checks on Beech Ward. On this inspection, we found that the provider had put in place processes to address the issue and staff on all wards had completed ward security checks as required.
- Aspen Ward was purpose built in 2016 and had been designed to remove ligature point risks. Fittings within the communal areas of the ward and patient bedrooms were non-weight baring and anti-ligature. Where staff had identified a potential ligature, this was reduced by use of observations and staff supervision of patients or monitored CCTV located around the ward.
- Staff had access to safety mechanisms such as access to anti-barricade unlocking systems and ligature cutters on all wards. Ligature cutters were replaced by staff after every use and there was a process in place to ensure this happened. All doors were anti-barricade and keys were readily available for staff to remove these in an emergency. We saw an anti-barricade door register that the provider asked staff to sign when they had completed training. Staff completed weekly and monthly checks on these and actions were identified and actioned where necessary.
- Maple and Beech wards complied with guidance on mixed-sex accommodation. There was access to a female-only lounge on both wards. All patient bedrooms had en suite bathroom facilities.
- There was no seclusion room on Maple and Beech Wards. Staff told us patients would be formally referred and transferred to the psychiatric intensive care unit (Aspen ward) if they required a period of seclusion.
- Aspen Ward's seclusion room had access to toilet facilities, outside space, a clock within view of the room and appropriate furnishings. Doors were robust and there were no apparent safety hazards. There was a window looking outside of the building where there was no access to the public or other patients or staff, except the garden maintenance staff. No one could see into the room from the outside as the window was fitted with an obscuring tint.
- All ward areas were visibly clean, had furnishings in good condition and were well maintained. The ward environments were bright and furniture was comfortable. There was evidence that the ward had been cleaned; cleaning records showed cleaning was completed regularly and we saw cleaning staff on all wards. All patients we spoke with said that the ward environment was always kept clean.
- Staff adhered to infection control principles and we saw information displayed around the wards about hand washing. There were hand gel dispensers at the entrance of the ward and we observed staff using them

correctly in line with infection control principles. There were facilities to wash hands in the clinic room. There were handwashing posters at all sinks. Environmental audits included monitoring of infection control were completed monthly.

- Staff adhered to Priory's policy on standards of dress, uniform and personal appearance and ward managers monitored this through audits of infection control. This was in place to reduce the potential risk of direct cross infection between patients who staff may have contact with in a clinical setting.
- There was a clinic room on every ward available for staff to monitor patients' physical health and administer medication. The rooms were fully equipped. Staff had access to an examination couch, blood pressure machine, weighing scales and medication fridge. There were emergency drugs and resuscitation equipment available.
- Staff monitored room and medication fridge temperatures and ensured they were kept within a safe range. Fridges were kept locked. There were bins available for the safe disposal of medication and needles. Equipment was clean and in working order. All medications and equipment were within expiry dates. There was one defibrillator held on Maple Ward and was shared with Beech Ward. The two wards were adjoined and the bag could be accessed easily and quickly in the event of an emergency. The emergency grab bag was available and checked nightly to ensure equipment was in date and working. The resus council required emergency medicines were accessible to staff, apart from one that was used to relieve angina (chest pain). This was located in an unmarked medicine cupboard on Beech Ward and only accessible to nursing staff with keys. This might cause a delay to the treatment of the patient.
- Nurses maintained and kept clinic room equipment clean. We saw stickers on equipment in clinic rooms indicate that it had been cleaned. Portable appliance testing (PAT) was carried out on equipment and certificates were held separately, centrally.
- Staff completed environmental risk assessments for the wards. We saw audits completed on wards for November 2017 to January 2018 with actions completed.
- On each shift a member of staff was nominated as a 'security nurse'. The security nurse was responsible for carrying out environmental checks of the ward on every shift. This included personal alarm and fire checks and general safety of the ward. The nurse also carried a set of keys for all the doors in the building. We reviewed security checks between December 2017 and date of inspection 2018, all security checks were present and complete.
- Fire checks were completed daily and a weekly test of the fire alarm system also took place within the hospital. There were trained fire marshals on all wards. Patients on all wards had a personalised evacuation plan indicating any assistance they might need in the event of a fire.
- All staff on the wards carried alarms that could be used to attract the attention of other staff in the event of an emergency or as a nurse call system. Staff were able to respond quickly in the event of an incident and staff from other wards could also respond to emergency alarms. There were nurse call systems in every bedroom for patients to use.

Safe staffing

- On Maple Ward, the staffing establishment was 24 whole time equivalent staff comprising registered nurses and healthcare support workers. There were seven vacancies. On Beech Ward, the staffing establishment was 27 and four vacancies. The staffing establishment for Aspen Ward the staffing establishment was 29 and there were seven vacancies.
- Between September 2017 and January 2018, 39% of shifts were covered by bank or agency staff on Maple Ward, 41% on Beech Ward and 22% on Aspen Ward. The hospital had implemented a system so that wards booked the same members of bank and agency staff to ensure consistency for the patients and ward. All shifts had been filled by either permanent, bank or agency staff between March and May 2017.
- Staff sickness rates for the period September 2017 to January 2018 were 4% for Maple Ward, 3% for Beech Ward and 2% for Aspen Ward. During the same period, Maple Ward had the highest staff turnover rate at 15% followed by Beech Ward 11%. Aspen Ward's staff turnover was 7%.
- The provider had estimated the number and grade of nurses required. The provider used a staffing ladder tool to determine the number of staff on shift. Staffing levels had been reduced in May 2017 on the wards. On review

following concerns raised by staff, levels were increased. Staff we spoke with told us the change was positive. Ward managers increased staffing levels if needed to support with increased patient observation levels.

- Aspen Ward had increased from five day staff to six. The ward manager told us they had noticed an improvement. This meant staff had more time to complete clinical duties and spend time with patients. Staff were always able to facilitate escorted leave. Staff took appropriate breaks.
- All wards had a registered nurse on every shift and present in communal areas. Patients we spoke with told us staff were always available if they needed to talk one-to-one.
- One patient on Maple Ward raised concerns about the ratio of female patients to male patients on the ward. At the time of inspection there were significantly more male patients on the ward then females.
- There were enough staff to safely carry out physical interventions when staff from other wards responded to an emergency alarm. We saw staff from Beech Ward respond to an emergency alarm located in another part of the hospital and this was done efficiently and quickly. Staff on Aspen Ward did not respond to alarms on other wards in order to maintain sufficient staffing levels for the safety of the ward.
- There was adequate medical cover 24 hours a day. A consultant psychiatrist provided medical input Monday to Friday between the hours of 9am-5pm. Out of hours on call medical cover was provided through a rota system and details were held in the staff office of the on call arrangements and contact details. Staff and patients reported no concerns about accessing a doctor and stated that the system worked well.
- The average mandatory training rate for Maple Ward was 88%. The average mandatory training rate for Beech Ward was 86%. On both wards, staff were up-to-date with their mandatory training in safeguarding adults (91% compliance for Maple Ward, 87% compliance for Beech Ward) safeguarding children and young people (86% compliance for Maple Ward, 91% compliance for Beech Ward). The provider's target for mandatory training was 90%. This had improved since our previous inspection.
- On Aspen Ward, 91% of staff were up-to-date with mandatory training. Staff were up-to-date with their mandatory training in safeguarding adults 100% compliance and safeguarding children and young people 100%. This had improved since our previous inspection.

Assessing and managing risk to patients and staff

- In the six months before inspection, Aspen Ward had 20 episodes of seclusion. Maple and Beech ward did not have any episodes of seclusion. There were no episodes of long term seclusion on any of the wards. We reviewed seclusion records and found these in order. Records clearly showed seclusion was used as a last resort. Staff recorded reviews of seclusion in patients' care records.
- In the six months before inspection there were 38 episodes of restraint on Aspen Ward on 22 different patients, 38 on Beech Ward on 15 different patients and 34 on Maple Ward on 21 different patients. None of the restraints on a patients were in prone (face down) position. The provider trained staff in the prevention and management of violence and aggression, including de-escalation techniques. Staff told us they would attempt to verbally de-escalate a potentially violent situation to avoid resulting in restraint where possible.
- Staff used rapid tranquillisation where appropriate and monitored the type of rapid tranquillisation given to patients. Staff recorded episodes in individual patient's care records. Rapid tranquillisation is an injection given to calm a patient down. Staff offered oral medication first and where rapid tranquillisation was used, staff recorded this in patient's observation charts and medics monitored patients appropriately in line with National Institute for Health and Clinical Excellence guidance (NG10).
- We found the provider's rapid tranquillisation policy did not accurately reflect the current NICE guidelines [NG10] on-Violence and aggression: short-term management in mental health, health and community settings, issued May 2015 and that deviation from the guidelines was not monitored effectively. Staff did not have access to guidance which covered individual patients medicines that were being used in the management of violence and aggression. We discussed this with the registered manager and medical director for the service. They immediately took action to review our findings and implemented actions to ensure this did not reoccur.
- We reviewed 19 care records across all wards, which included detained and informal patients. Staff undertook a risk assessment of every patient on

admission and updated these risk assessments regularly, including after an incident. Staff used the Priory's own risk assessment tool, which captured the individual's historical and current risk. We saw that all these risk assessments were up-to-date and regularly reviewed. However, on Beech Ward, we found one risk assessment for a patient who had been admitted to the ward for more than seven days that was not fully complete. There was no risk formulation despite being completed within 24 hours of admission and reviewed six days later. We alerted staff at the time of inspection due to the seriousness of risks identified in the patient's risk history.

- Staff only used blanket restrictions when justified, for example, to ensure the safety of all patients on the ward. Aspen ward had a list of restricted and banned items appropriate to/for a psychiatric intensive care unit.
- On Maple and Beech wards, informal patients could leave at their will and signs were displayed on the doors of the ward exits to remind informal patients of this. Staff told us that patients were required to ask the staff to open the door for them in order to keep other patients safe.
- Staff used observations to mitigate risks to patients. Staff assessed patients appropriately and recorded the reasons for levels of observations in care records. We saw that observation charts recorded the actual time at which the patient was observed and what the patient was doing at that time. This was to ensure that patients could not predict their observation times in order to engage in risk-related behaviour, such as self-harm. This helped to keep patients safe.
- Staff searched patients in line with Priory's policy on searching service users and their belongings in a treatment environment. This occurred on admission to the wards, thereafter, staff only searched patients if individually risk assessed and care planned or on return from leave if their risk assessment indicated a specific risk. Staff sought and recorded patients' consent to carry out these searches.
- Maple and Beech wards had experienced patients bringing illegal substances on to the ward. The ward managers put measures in place to manage this, including risk assessed personal searches and a request to the police for detection dogs to come to the ward. Staff also discussed this concern with patients in one-to-one meetings and morning meetings. We saw minutes from the patients' meetings that showed staff regularly discussed and discouraged the issue of illicit substances. Staff encouraged a peer-led attitude to help stop substances being brought onto the ward.
- Staff we spoke with on all wards were knowledgeable about the provider's safeguarding policy and procedures. All staff could name the safeguarding leads within the hospital and knew the process to escalate concerns. The safeguarding leads across the hospital met on a weekly basis to discuss safeguarding referrals. The service notified CQC of all safeguarding concerns and referrals related to patients using the service.
- Medicines were stored safely and securely on all wards in locked clinic rooms. There were appropriate arrangements in place for recording the administration of other medicines. Staff completed these clearly and fully. Records showed that patients received their medication when they needed it. If patients were allergic to any medicine, this was recorded on their prescription chart. However, we found that staff did not always write patients' names and opening dates on topical creams and ointments. This could have resulted in the medicine being used for more than one patient and resulted in cross contamination of the medicine.
- Medicines that require additional controls because of their potential for abuse (controlled drugs) were stored securely and recorded correctly. However, we found confiscated illicit substances on Beech Ward being stored in the locked medicine cabinet. The provider had no clear policy in place regarding storage or disposal of illicit substances found on patients. The hospital had started to liaise with the local police to ensure that it/ staff stored and disposed of illicit substances appropriately following concerns raised during our inspection.
- We saw good systems of recording medication and reporting medication errors and learning lessons from these errors. Ward staff and the external pharmacists audited medication. A pharmacist visited the ward weekly to audit medication and medication charts. Medication was delivered from the pharmacy to hospital by courier and collected by designated nursing staff.
- The pharmacist produced weekly reports which staff accessed online. There were also links to updates on National Institute for Health and Clinical Excellence

guidelines. The pharmacist also attended quarterly clinical governance meetings with the hospital to present a quarterly report and gave staff updates through a newsletter.

- Children were able to use a visitor's room to visit patients on the wards. There was a visitor's policy which contained guidance to the updated 2015 Mental Health Act Code of Practice. The policy stated that visits by children to parents, whether detained or not, were central to the maintenance of healthy relationships with parents or other relatives who are in hospital. Ward staff and the medical team carried out risk assessments to determine whether staff supervised these visits.

Track record on safety

- There were no serious incidents on any wards since the previous inspection.
- Staff we spoke with knew how to report incidents. Staff received feedback and learning about incidents from senior staff in handovers or supervision. Feedback was disseminated from senior managers to ward managers verbally during morning meetings and through emails. The ward managers fed back learning to staff in staff meetings and through the use of a communication folder and in emails. Changes were made following learning from incidents. For example, on Maple and Beech wards, staff improved safety by removing and securing items used to damage ward property. On Aspen Ward, changes to staffing and shifts meant that staff were better able to manage incidents. This lead to a reduction in incidents that were usually higher at specific times of day.
- Staff were supported with debriefs and supervision following incidents. The psychologist facilitated reflective practice sessions fortnightly. Reflective practice is the ability to reflect on one's actions to engage in a process of continuous learning.
- There was a risk management meeting and a clinical governance meeting held monthly. Staff shared learning between wards and produced a risk bulletin, which was then circulated to all staff. The Priory group shared learning from incidents across their services during governance meetings. The director of clinical services, conducted team incident reviews and determined lessons learned. Senior managers acted quickly to ensure incidents did not reoccur and supported ward managers to implement changes.
- Staff were open and transparent with patients and explained when something went wrong. This was in line with the provider's duty of candour policy. We saw examples on all wards where staff had discussed with patients and carers when something went wrong.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that patients' topical medicines are individually labelled to prevent cross-infection between patients and help prevent errors in their administration, as detailed in the provider's medicine's management policy

Action the provider SHOULD take to improve

- The provider should ensure that its rapid tranquillisation policy accurately reflects the National Institute for Health and Care Excellence (NICE) guidelines [NG10] Violence and aggression: short-term management in mental health, health and community settings, issued May 2015.
- The provider should ensure they effectively monitor any deviation from National Institute for Health and Care Excellence (NICE) guidelines [NG10] Violence and aggression,and record the rationale for doing so.
- The provider should ensure detailed guidance is available to medical and nursing staff when prescribing, managing and administering patient's medicines in the management of violence and aggression.

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 provider did not ensure that patients' topical medicines were individually labelled to prevent cross-infection between patients and to help prevent errors in their administration.** This was a breach of regulation 12(2)(g)

This section is primarily information for the provider

Enforcement actions

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.