Woodbourne Priory Hospital

Quality Report

21 Woodbourne Road,Edgbaston,Birmingham,West Midlands,B17 8BY
Tel:(0121) 434 4343
Website://www.priorygroup.com

Date of inspection visit: 16/02/2017
Date of publication: 09/03/2017

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

Overall summary

- We carried out a focused inspection on Aspen Ward.
- We found the layout of the ward meant that staff could not see all parts of the ward. Staff had mitigated this with regular observations of the ward. However, incidents had occurred between patients while staff were elsewhere in the building carrying out observations.
- We found that following the reporting of incidents to staff, measures were immediately put in place to safeguard patients on the ward.The service had taken steps to keep patients safe and to reduce the likelihood of further similar incidents from occurring.
- The service had reported the incidents to external agencies including the police and local authority where appropriate.
- The service had put temporary measures in place to ensure patients were kept safe while they found a longer term solution. The service were also in the process of investigating the incidents internally and learning from the incidents.
- Staffing levels on Aspen, Maple, Beech and Mulberry wards were appropriate and met required staffing levels for the ward.
- Bank and agency staff were inducted to the ward and all nursing staff employed on a bank or agency basis were interviewed to ensure they were suitable for the position
- Patient records showed that risk assessments had been undertaken and were comprehensive and completed to a thorough and high standard. Records showed staff had completed regular and appropriate levels of observation of patients and had recorded these effectively.

Summary of findings

Contents

Woodbourne Priory

Services we looked at:
Psychiatric intensive care unit, acute 18-25 wards and acute child and adolescent mental health services ward

Summary of this inspection

Background to Woodbourne Priory Hospital

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.

At the time of inspection there was a manager in place.

The service can accommodate up to 69 patients. Maple and Beech wards are adult acute mental health wards and between them have 28 beds. Oak Ward is an adult eating disorder ward and has eight beds. Rowan Ward is a high dependence unit for adolescents and has six beds. Mulberry Ward is child and adolescent mental health service unit and has 15 beds. Aspen Ward is a psychiatric intensive care unit and has 10 beds. All wards are mixed gender.

This service was inspected on 5 November 2015. There was one compliance action required due to a breach of regulation 17(2)(b). The service was then reinspected 5 May 2016 and found to be compliant.

Our inspection team

The team was comprised of three CQC inspectors.

Why we carried out this inspection

Care Quality Commission needed to ensure that all appropriate measures were in place following reported incidents on Aspen Ward.

We carried out a focused inspection on Aspen Ward. The purpose of the visit was to ensure the service acted appropriately to ensure no other patients were at risk of a similar incidents occurring.

How we carried out this inspection

During the inspection visit, the inspection team:

- looked at staffing rotas to ensure there were adequate numbers of staff covering the ward.
- reviewed the process of staff and agency induction to the ward; including handovers between shifts.
- spoke with three members of staff including the registered manager, the ward manager and the director of clinical services.
- looked at the environment of the ward.
- looked at seven patient records.

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

Safe

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

Safe and clean environment

- We inspected the ward layout of Aspen Ward, psychiatric intensive care unit. The communal area of Aspen Ward was overlooked by a nurses station where staff could observe all parts of the lounge. There was a viewing window into a separate female lounge from the nurses station.
- The patients' bedrooms were located on a single corridor which was zoned to ensure male and female bedrooms were located at opposite ends of corridor. On the same corridor there was a quiet lounge for patients' use.
- We found that the layout of the ward meant that staff could not observe all parts of the ward. There were blind spots where patient areas could not be easily seen from the nurses station. This included the garden area, the corridor where patients bedrooms were located and the quiet lounge located on the corridor where patients bedrooms were.
- To mitigate blind spots, staff carried out observations of the ward and outdoor areas at irregular intervals totaling four times an hour. Staff also accompanied patients who were using the garden area. We saw records of observations showing staff had checked all rooms and communal areas as well as individual patient bedrooms. Each patient had their own observation sheet and we saw staff had completed these appropriately. We saw staff had carried out checks of the bedroom corridor at regular intervals.
- We found that some incidents had occurred in patient bedroom's and the quiet lounge while staff were elsewhere in the building carrying out observations. We found that following the reporting of incidents to staff, measures were immediately put in place. The service had reported the incidents to external agencies including the police and local authority where appropriate. The service took steps to keep patients safe and to reduce the likelihood of further similar incidents from occurring.
- Staff increased levels of observation of patients at risk to ensure the safety of all patients on the ward. The ward stationed a staff member to constantly observe the patients' corridor and we saw this in place on the day of our inspection. This was in order to ensure a similar incident could not occur again in blind spots. We interviewed the ward manager who told us that this is not a long term solution as it required extra staffing but would remain in place until a long term solution was found. The hospital director advised us that the service was in the process of finding a longer term solution.
- The service were in the process of investigating the incidents internally and ensuring future incidents of a similar nature did not occur. During our inspection we found that they had done everything practicable to mitigate the risk of a similar incident reoccurring.

Safe staffing

- We reviewed the staffing rota's for Aspen Ward. We found that there were adequate numbers of staff available on shift when incidents had occurred.
- In addition to reviewing staffing levels on Aspen, we reviewed staffing levels on Maple Ward, Beech Ward and Mulberry Ward.On all wards we found that there was always at least two qualified nurses on day shift between 8:00am and 8pm and one qualified nurse on night shift between 8pm and 8am. In all cases we found staffing levels to be appropriate to the need of the patient group and in line with the Priory staffing compliment tool.
- We reviewed use of bank and agency staff and found that most staff were block booked and familiar to the ward. All new staff to the ward received an appropriate induction from a senior member of staff and were orientated to the ward by regular staff members.
- All nursing staff employed on a bank or agency basis were interviewed by either the ward manager or the director of clinical services to ensure they were suitable for the position.
- We reviewed 15 staff induction records and found that all but one had been completed and signed off by a senior member of staff.

Assessing and managing risk to patients and staff

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

- We reviewed seven patient records and reviewed the risk assessments of four patients. We found that risk assessments were comprehensive and staff had looked at all areas of risk that could be predicted. We found that where incidents had occurred between patients, there had been no indication of risk in this area when they were admitted to the ward. We found that staff could not have predicted the incidents which occurred based on the presentation of the patients involved.
- Of the seven records we reviewed, all of them showed that staff had completed regular and appropriate levels of observation of patients and had recorded these effectively.