The Atarrah Project Limited

Milestones Hospital

Inspection report

The Street
Catfield
Great Yarmouth
NR29 5BE
Tel: 01603782200
www.milestoneshospital.co.uk

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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	Inadequate
Are services safe?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

This inspection was an unannounced, focused inspection in response to concerns we had in relation to patient safety, incident management, safe staffing and the use of restraint.

We looked at specific key lines of enquiry during this inspection therefore we have reported in the following domains:

- Safe
- Well-led

Following our inspection, we issued an urgent Notice of Decision to restrict further admission among a number of other conditions. In the following weeks after the inspection the service notified us that it had became insolvent and all patients were relocated to other services prior to it closing.

We changed the ratings for Milestones Hospital to inadequate for Safe and Well-led and suspended the ratings for Effective, Caring and Responsive because:

- The service did not ensure that patients met the inclusion/exclusion admission criteria and were unable to meet the needs of some patients with complex conditions.
- The ward environment was not always safe. Patients were frequently able to access items to cause deliberate self-harm and the hospital had high numbers of deliberate self-harm incidents requiring treatment at the local acute hospital emergency department.
- Staffing was not structured in line with patient acuity and clinical need. Staffing levels did not always ensure enough staff were available to maintain patient enhanced observations.
- The provider had not ensured that patient observations were completed in line with patient care plans or the provider's patient observation policy. We saw closed circuit television (CCTV) footage where staff failed to complete enhanced patient observations for prolonged periods of time and falsified records.
- The provider did not ensure that all staff completed or were up to date with their mandatory training. Only 27% of staff had completed their physical intervention training and only 41% of staff had completed first aid training which included basic life support training.
- Staff did not always manage risks to patients well. Patients did not always have adequate nursing assessments, associated care plans, risk assessments and positive behaviour support plans in place to enable staff to safely manage patients. Staff did not always act to prevent or reduce risks or respond to changes in patient risks.
- The service did not always manage patient safety incidents well. Managers did not fully investigate incidents and learning from incidents was not always completed or shared with staff. Staff did not always complete post incident checks with patients including checking for injuries or completing body maps.
- Our findings demonstrated that the provider's governance processes were not operating effectively. Although they had identified where improvements were needed to provide safe care, these were not implemented. The process for managing risk was inconsistent and ineffective. Senior leadership was reactive rather than proactive in identifying issues around risk and performance. They were not supporting the team to deliver care that was consistent and effective when caring for patients with complex and challenging behaviours.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Inadequate 	This inspection was an unannounced, focused inspection in response to concerns we had in relation to patient safety, incident management, safe staffing and the use of restraint. We looked at specific key lines of enquiry during this inspection therefore we have reported in the following domains: • Safe • Well-led Following our inspection, we issued an urgent Notice of Decision to restrict further admission among a number of other conditions. In the following weeks after the inspection the service notified us that it had became insolvent and all patients were relocated to other services prior to it closing. We changed the ratings for Milestones Hospital to inadequate for Safe and Well-led and suspended the ratings for Effective, Caring and Responsive because: • The service did not ensure that patients met the inclusion/exclusion admission criteria and were unable to meet the needs of some patients with complex conditions. • The ward environment was not always safe. Patients were frequently able to access items to cause deliberate self-harm and the hospital had high numbers of deliberate self-harm incidents requiring treatment at the local acute hospital emergency department. • Staffing was not structured in line with patient acuity and clinical need. Staffing levels did not always ensure enough staff were available to maintain patient enhanced observations. • The provider had not ensured that patient observations were completed in line with patient care plans or the provider's patient observation policy. We saw closed circuit television (CCTV) footage where staff failed to complete enhanced patient observations for prolonged periods of time and falsified records.

Summary of findings

- The provider did not ensure that all staff completed or were up to date with their mandatory training. Only 27% of staff had completed their physical intervention training and only 41% of staff had completed first aid training which included basic life support training.
- Staff did not always manage risks to patients well. Patients did not always have adequate nursing assessments, associated care plans, risk assessments and positive behaviour support plans in place to enable staff to safely manage patients. Staff did not always act to prevent or reduce risks or respond to changes in patient risks.
- The service did not always manage patient safety incidents well. Managers did not fully investigate incidents and learning from incidents was not always completed or shared with staff. Staff did not always complete post incident checks with patients including checking for injuries or completing body maps.
- Our findings demonstrated that the provider's governance processes were not operating effectively. Although they had identified where improvements were needed to provide safe care, these were not implemented. The process for managing risk was inconsistent and ineffective. Senior leadership was reactive rather than proactive in identifying issues around risk and performance. They were not supporting the team to deliver care that was consistent and effective when caring for patients with complex and challenging behaviours.

Summary of findings

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Background to Milestones Hospital

Milestones Hospital is an independent mental health hospital that provides support and treatment, with a rehabilitation focus, for up to 18 women with complex and challenging mental health disorders.

The hospital is registered to carry out the following regulated activities:

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

The hospital had 10 beds in Magnolia House and capacity to provide accommodation and care for up to eight patients in the Mews which is a separate building within the grounds with self-contained flats. At the time of inspection 12 patients were admitted, 10 of whom were detained under the Mental Health Act, in Magnolia House with two being informal patients (those in the Mews).

The service had not had a consistent registered manager since April 2020. A manager was employed between June and September 2020 but did not formally register with the CQC. The service had a temporary unregistered manager between September 2020 and January 2021 when a new manager was employed on 13 January 2021.

The service was last inspected in March 2020 and was rated as requires improvement overall and within the safe, responsive and well led domains with caring and responsive rated as good.

How we carried out this inspection

This inspection was an unannounced, focused inspection in response to concerns we had about patient safety, safeguarding, incident management, and safe staffing. We carried out this inspection to look into these concerns and to explore the governance processes in place at the hospital.

We looked at specific key lines of enquiry during this inspection therefore we have only reported in the following domains:

- Safe
- Well-led

Before the inspection visit, we reviewed information from the service about recent incidents that had occurred. This included a review of incident reporting and management, patient records and safeguarding referrals. We also received information from the local safeguarding authority and local acute hospital safeguarding team regarding patient safety incidents.

During the inspection, the team:

- spoke with the nominated individual (hospital director), governance lead and a non- executive director
- spoke with nine additional staff from a variety of roles including ward managers, nurses, occupational therapists and support workers.
- looked at four care and treatment records of patients
- looked at staff training records

Summary of this inspection

- reviewed staffing rotas
- reviewed infection control measures
- reviewed incident logs, forms and reviews
- reviewed safeguarding practices
- reviewed CCTV footage
- looked at a range of policies, procedures, meeting minutes and other documents relating to the running of the service

Areas for improvement

Following this inspection CQC took urgent action to suspend patient admissions at the hospital. The below requirements detail which regulations were not being met by the provider. The provider sent CQC a report detailing what action they were going to take to meet these requirements but became insolvent and closed before they were able to make the improvements.

Action the provider MUST take is necessary to comply with its legal obligations. Actions the 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.

Action the service MUST take to improve:

- The provider must ensure that it reviews its inclusion/exclusion admission criteria in order to ensure that the service has the necessary resources to meet the needs of patients and that staff are suitably qualified, skilled, competent and experienced to meet the needs of patients. (Reg 9 (1) (b))
- The provider must ensure that environmental risks are reviewed and actions are taken to mitigate risks (Reg 12(2)(d))
- The provider must ensure they have enough nursing and support staff to keep patients safe, to carry out physical interventions safely, to complete patient observations levels and to offer patients activities (Reg 18(1))
- The provider must ensure that patient's dignity is protected during observations by employing enough female staff to accompany patients to bathrooms. (Reg 10(2))
- The provider must ensure that patient observations are completed in line with patient care plans and the provider's patient observation policy (Reg 12)
- The provider must ensure that staff have breaks during the working day and that staff have breaks between completing patient observations (Reg 18(1))
- The provider must ensure that all staff including agency staff have completed and are up to date with mandatory training for their role, including basic and intermediate life support, safeguarding and physical intervention (Reg 18(2))
- The provider must ensure that all patients have a nursing assessment and an associated care plan, a positive behaviour support plan, and risk assessment in place, and that these are personalised and updated in line with changes to the patient's needs and risks. (Reg 12(2)(a))
- The provider must ensure that all staff are familiar with patient care plans, positive behaviour support plans and risks assessments to ensure staff can safely manage patients' risks (Reg 12(2)(a))
- The provider must ensure that learning from incidents is identified, shared with staff and changes are made as a result of the learning (Reg 17(2)(b))
- The provider must ensure that all incidents are recorded in patient records (Reg 17(2)(b))
- The provider must ensure that physical health checks and body maps highlighting injuries are completed for patients following incidents of restraint and self-harm (Reg 12(2)(a))

Summary of this inspection

- The provider must ensure that it complies with its own governance recommendations identifying areas for improvement and to drive quality improvement at the hospital (Reg 17(2)(a-f))
- The provider must ensure that they have appropriate oversight to identify areas of concern and identify when policies are not being followed, to provide assurance that systems in place are working (Reg 17 (2)(a-f))
- The provider must ensure that it complies with its own policy and National Institute for Health and Care Excellence guidance for the administration and post administration physical health checks following rapid tranquilisation. (Reg 12(2)(g))
- The provider must ensure that staff follow safeguarding procedures to protect patients from abuse and sexual exploitation. (Reg 13(1)(2) (3))

Action the service SHOULD take to improve:

- The provider should provide the infection prevention and control (IPC) lead with specialist training in IPC so they can carry out the role.
- The provider should ensure that it monitors and audits IPC actions to ensure the service is safe for patients and staff.
- The provider should record staff and patient debrief sessions following safety incidents.
- The provider should reintroduce community meetings to ensure that patients' views are heard and listened to.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Well-led	Inadequate

Are Long stay or rehabilitation mental health wards for working age adults safe?

Inadequate

Our rating of this service went down. We rated it as inadequate because:

- The service's admission criteria was not clear which meant that it admitted patients with acute complex and challenging conditions whose needs could not be met by the service.
- The ward (Magnolia House) environment was not always safe. Patients were able to access ligature points and implements to self-harm. The environmental ligature risk assessment had not been updated since April 2020 despite changes in room usage. The main patient bedroom room corridor had multiple recesses with no blind spot observation mirror.
- The service did not complete infection, prevention and control (IPC) audits, for example; environmental, cleaning records, staff hand washing and touchpoint cleaning, which meant that they were unable to identify and respond to cleanliness issues. IPC oversight had been part of the role of the physical health nurse who was no longer a substantive employee and had not been allocated to other staff to back fill until a new physical health nurse was employed. The physical health nurse confirmed that they had not been provided with any specific training for their role and would have welcomed further direction on what was required.
- Staff did not always follow COVID 19 management arrangements to restrict the number of people allowed to be in the smaller rooms. We saw six staff at a time in the nurses' office. We raised this as a concern on the first day of the inspection and a notice was placed on the door providing safe numbers allowed in the room. Staff did not have a sign in or out of the building record which meant that in the event of a fire they would not know how many people were in the building. We raised this as a concern on the first day of our inspection and we saw that it was in place by the end of the day.
- The service did not have enough nursing and support staff to keep patients safe and staffing was not always structured in line with patient acuity and clinical need. The provider had attempted to recruit additional staff however this had limited impact on staffing availability. The vacancy rate for clinical team leaders was 25%, registered mental health nurses was 85% and healthcare assistants was 12% against the set staffing establishment. The service relied heavily on bank and agency staff. Up to 80% of staff on night shifts and up to 70% of staff on day shifts were agency staff. Not all of the agency staff were familiar with patients or their needs despite having access to patient handovers and electronic records. Patients had complained to CQC regarding this and had cited this as a reason for escalating deliberate self-harm as the agency staff did not know them. On reviewing the rotas, we noted that staff occasionally worked longer shifts than would be deemed safe; for example, we saw evidence of a staff member working a 15-hour shift and another example of an agency staff member shown on the rota for 14 consecutive night shifts and having only seven nights off during a period of six weeks. Senior staff did not have oversight of this.
- Three staff also told us that there were not always enough staff to have regular 1:1 time with patients and that activities were often cancelled due to too few staff. This was also noted in the patient survey and raised by patients with CQC. Two patients reported that they deliberately self-harmed in order to get attention as they did not receive it otherwise.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

- Due to the COVID19 pandemic we were restricted in the time we were able to spend on site speaking with staff, so in the two weeks following the inspection we requested times when we could complete remote interviews with staff on duty. The service was unable to accommodate this as it was struggling to cover breaks for staff and further staff away from the ward would have been unsafe.
- There were not always enough available female staff on duty to provide enhanced observations for patients who required monitoring in bathrooms for personal care. Male staff told us that if they were observing a patient in this situation who needed to use the bathroom then they would call for a female member of staff. On occasion, if the patient needed to use the bathroom urgently then they would have to accompany them. We saw evidence in a patient's records of the negative impact of the loss of dignity as a result of one of these incidents.
- We reviewed copies of the planned staff rotas for the period 1 December 2020 to 20 January 2021 but, despite requesting, were not provided with confirmation of actual staff on duty so were not assured that the rota represented the actual staff available on shift.
- Three staff we spoke with said that they did not always get their breaks during their shifts. Staff were conducting enhanced patient observations for extended periods of time without a break. We reviewed the allocation sheets for shifts between 1 December 2020 and 20 January 2021. Not all allocation sheets were provided but we saw consistently high levels of clinical observations were required for the management of some patients. This resulted in staff often undertaking enhanced observations for 10 hours out of a 12-hour shift. This is not considered best practice in line with National Institute for Health and Care Excellence (NICE) guidance or the National Mental Health Nurse Directors Forum National Policy Template for Supportive Observation and Engagement, which recommends staff do not undertake enhanced observations continuously for longer than two hours. It also did not follow the provider's own observation policy which stated no nurse should carry out supportive observation for longer than one hour at a time.
- The provider had not ensured that all staff had completed or were current with their mandatory training. Only 41% of staff had completed their first aid training which included basic life support. There were no intermediate life support trained staff.
- The service had not ensured staff had received or were up-to-date with restrictive intervention training for their role. Data supplied by the service showed that training rates were 27% (nine out of 34) compliant across the clinical staff. Of the nine staff with up-to-date training only four were fully compliant with the other five staff only having completed breakaway training. Breakaway training compliance for non-clinical and medical staff was also inconsistent with 44% compliance (four out of nine staff compliant) which did not include the medical staff. Senior staff commented that they had been unable to access face to face training during the pandemic and were unsure if they could continue to use their current trainer due to accreditation issues. Staffing rotas did not display which staff were up to date with physical intervention training, so we were not assured that there was always a staff member on duty with current training.
- There was no system to confirm that agency staff who worked at the organisation had their mandatory training compliance reviewed following their initial induction. This meant that the service had no oversight of the mandatory compliance of regular agency staff who had worked there longer than 12 months.
- The service had recently introduced specialist training in the form of personality disorder training from one of the clinical psychologists. Data supplied by the service showed that 17 out of the 34 staff who required it had completed this on either 20 or 27 November 2020. We were not supplied with any information on what the training consisted of.
- Staff did not always manage risks to patients and themselves well. Staff did not always establish or follow nursing assessments, associated care plans and risk assessments to safely manage patients. Risk assessments were not always updated following incidents. Where updated they consisted of a general note about the incident rather than assessment of what triggered the incident, what worked to manage the patient risk, what escalated the risk and what changes were required. Information was inconsistent on risk assessments such as the level of patient observations.
- Staff completed positive behaviour support (PBS) plans which were updated following incidents. However, information was often not followed when interacting with patients. Patient care plans and PBS plans were detailed but not easily accessed as they were in an electronic format which meant staff having to access them on the limited computer

terminals available. As a high proportion of agency staff worked at the hospital, we were not assured that all staff were familiar with patient risks. PBS plans were not reviewed to see if the plan was working to prevent incidents from occurring. Staff did not always act to de-escalate patients in line with their PBS plans and we were not assured that staff were familiar with patient risks.

- There was a failure to instigate patient or room searches following patients disclosing that they had items they could use to harm themselves. We saw evidence in patient records that in January 2021 a patient disclosed to staff that they had self-harmed with a broken implement and would do so again. The patient further harmed themselves using the same or a similar instrument three days later. During the same period no room searches were recorded. Had searches been conducted the patient may not have had the opportunity to harm themselves again.
- Some staff failed to carry out enhanced patient observations according to patient need and hospital policy, and falsified observation records. During our inspection, we observed closed-circuit television (CCTV) recordings that showed that some staff who should have been conducting enhanced patient observations failed to complete them between extended periods of time. The patient observation charts for the same period had been completed by staff and recorded that checks had taken place. The observation records also failed to record patient activities that had taken place, such as a patient leaving their room for a period of time. Senior staff confirmed that they did not routinely carry out spot-checks of CCTV footage or check that the monitoring of patients was effective.
- Staff did not always monitor patients' physical health appropriately. There was a failure to undertake monitoring of physical health and food intake of a patient with a known eating disorder resulting in the patient collapsing and requiring an acute hospital admission. Staff failed to consistently perform neurological observations for patients following head banging incidents. National Early Warning Score (NEWS) forms or neurological observation forms were not routinely used. This was a known concern discussed during the January 2021 Governance meeting with NEWS completion compliance at 57%, but this had not been addressed prior to the inspection.
- Following physical intervention incidents, we could not find any evidence of post-incident physical health checks or patient body maps in patient records or on physical intervention forms.
- During our inspection we reviewed 24 physical intervention forms completed following physical restraint of service users for incidents dated from 1 November 2020 to 17 January 2021. We were not assured that these were all of the forms completed as they had not been filed appropriately and were found in several different places. Only nine of the 24 had been signed by the clinical team leader or manager and had evidence that service user post-intervention counselling had been undertaken/offered and only six out of the 24 recorded any staff debrief.
- Medicines management was not robust. Staff did not always ensure that patients took their medicines safely. Staff did not always follow their own policy when recording in patient records when rapid tranquilisation had been given. We reviewed 11 episodes of rapid tranquilisation for a single patient in December 2020. In two cases the care records entries did not indicate that medication had been given intramuscularly (IM). Following administration, staff did not always follow the provider's policy or National Institute of Health and Care Excellence (NICE) guidance to record that physical observations had been performed. NICE recommends that after rapid tranquilisation, staff should monitor side effects and the patient's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status.
- We were concerned that staff did not recognise and take immediate action in September 2020 following identification of a vulnerable patient at risk of being sexually exploited. This resulted in a further incident of possible abuse in November 2020. Senior staff had not recognised or raised a safeguarding concern when it was escalated to them after the initial incident and failed to put protective measures in place to prevent further incidents.
- The service did not always manage patient safety incidents well. The provider's incident log recorded incidents which occurred at the service but staff recording of incidents was inconsistently reported. Actions were not always clearly reported and did not provide a complete reflection of what occurred to respond to the incident. Staff did not always complete or record physical observations or body maps (or refusals) after possible patient harm or physical intervention incidents. Managers did not fully investigate or review incidents and learning from incidents was not always completed or shared with staff.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

- There were a high number of deliberate self-harm incidents occurring involving patients cutting and burning themselves and swallowing objects despite patients being on enhanced monitoring and clinical observations. These had been increasing and there had been 53 incidents of deliberate self-harm (DSH) for three patients between 01 November 2020 and 01 of January 2021 with 25 acute emergency department attendances and one overnight admission. Despite the high number of incidents, there was poor evidence that staff updated patients' risk assessments or undertook actions to prevent such incidents recurring. The patient survey undertaken in October 2020 had an 83% response rate with 50% of patients reporting that they did not feel safe.

However:

- We saw that the ward appeared clean during our on-site inspection. There were signed, daily cleaning schedules and the service had put extra infection prevention and control (IPC) measures in place for patient and staff protection due to the COVID19 pandemic. For example; they had increased their cleaning staff hours, instigated touchpoint cleaning four times a day on the ward (not at The Mews) for highly used equipment such as door handles, keyboards or phones, and arranged for a specialist service to disinfect the environment, including vehicles used by staff to convey patients, every 28 days.
- Infection prevention control was discussed during the provider's monthly clinical governance meeting and 95% of staff were up to date with their infection control training.
- As part of their COVID19 prevention measures staff recorded the temperatures of all staff/visitors entering the building for the first time each day. If the temperature was elevated staff were advised to return home and access a COVID19 test. All staff were offered tests on a weekly basis and a programme was underway to vaccinate all patients and staff who were willing.
- Staff told us that they were sometimes offered debrief sessions following incidents, but that these were not formally recorded. Staff also told us that individual incidents were discussed during staff handovers and at morning briefing sessions. We did see some evidence of this at the briefing meeting we attended but recording the minutes of the briefing meetings had only commenced in the week of the inspection. The provider told us that they would be establishing weekly incident review/lessons learned meetings going forwards.

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate because:

- Leadership at the organisation was poor due to inconsistent management leading to a lack of staff direction. There had been a period of nine months with no consistent registered manager and clinical team leader vacancies which had resulted in the ward management being ineffective and lacking guidance. A senior director had stepped in to perform the registered manager role, but this was insufficient to support the team leaders who had extra responsibilities to perform leading to a lack of support for junior staff.
- The service had performed patient and staff satisfaction surveys in October and December 2020 respectively. The responses were red, amber, green (RAG) rated. Overall staff comments were more negative than positive with some comments made such as "I do not feel valued and when I have issues these are never taken seriously. This gives the impression that you are just a number". Patient comments were mixed however, 50% of patients reported that they did not feel safe at the service.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

- The provider failed to follow its own governance procedures. The service held monthly clinical governance meetings in which staff discussed a range of governance issues including incidents, staffing, infection control and safeguarding incidents. Despite the meeting minutes setting actions in these areas, for example undertaking incident investigation, the provider had not addressed the issues. Therefore, we were concerned that the provider did not follow the suggested overarching quality assurance process of issues identified.
- The provider had attempted to improve their governance systems however these had not led to sustainable improvement as demonstrated by the findings of this inspection. The service had employed a governance lead who had identified governance gaps and introduced systems and processes to improve overall governance. However, they had not been embedded and implemented by the senior management. Systems were not operating effectively, and performance and risk was not always managed well. For example, although staff had begun to report on patient incidents and there was more comprehensive classification of patient incidents, the results of this analysis were not used to drive quality improvement at the hospital. We found that as incidents were not investigated there was no key learning shared to help prevent incidents from occurring again.
- The provider failed to implement an effective audit system to ensure that the quality of care was regularly assessed, monitored and that issues identified as part of the audit were acted upon. Although discussed in the November and December 2020 governance meeting minutes, the provider had failed to ensure that a suggested audit of record keeping had been addressed. Patient management plans were not reviewed to check if they were effective and managers had not ensured regular audits were undertaken to identify if patient care documents were reviewed against patient progress or presentation.
- During our inspection we identified a lack of safe systems of working. The provider's management of patient paper records, and general documentation was poor with documentation completion/filing being inconsistent. We found overflowing paperwork 'in-trays' in the nurses' office which contained a multitude of different documents including observation sheets, patient food intake records, health and safety information and handwritten undated and unsigned notes regarding patient discussions with external agencies and staff curriculum vitae. Staff were unable to locate pertinent documents for example physical intervention forms, ligature audits and handover documentation.
- The provider's working policy documents were not always fit for purpose. During our inspection we reviewed a selection of policies including the observation policy, incident reporting policy, management of violence and aggression, and staff levels policies. These were either out of date or in draft form and did not all reflect latest guidance or contain sufficient detail for staff. We requested the policy for managing risk assessment however the provider did not have one. The staff levels policy was the only staffing policy available and did not provide any guidance on length of shifts, breaks, or the number of shifts allowed to be worked in a time period. It was noted in the governance meeting minutes from November and December 2020 that a significant amount of work involving a range of staff was required to review and update policies and procedure documents. This had not been achievable due to the vacancy rate and lack of clinical leadership.
- The managers of the service did not have oversight of practising privileges for clinical staff not directly employed. Practising privileges are a well-established system of checks and agreements whereby doctors can practise in hospitals without being directly employed by them. There was a limited induction form but no oversight of indemnity insurance, scope of practice, continuing professional development, revalidation, appraisal or mandatory training.