Priory Healthcare Limited

# Barnt Green

**Inspection report**

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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 effective? | Inadequate |
| Are services caring? | Requires Improvement |
| Are services responsive to people's needs? | Requires Improvement |
| Are services well-led? | Inadequate |

# Summary of findings

## Overall summary

Priory Barnt Green is an independent mental health hospital provided by the Priory Group. The hospital had one ward open at the time of our inspection. Bittell ward was a ten bed Psychiatric Intensive Care unit for female patients aged 18 and over. The hospital planned to open an acute mental health ward and a private ward but could not do this until they had recruited staff. The provider had submitted an application to increase the number of wards as this had been limited at the time of registration.

We carried out an inspection of the hospital on 28 and 20 June 2021. Following the inspection, we informed the provider of our immediate serious concerns and warned them of possible urgent enforcement action. The provider was told to submit two action plans. The first within three hours that described how it was going to immediately address CQC concerns. The second within two working days with more information about how it would continue to address those concerns. After submitting the first action plan the provider decided to close the hospital for a period of time as they did not feel they could keep patients safe if they stayed open. The provider then submitted their second action plan and informed us of further patient safety incidents that had taken place. We decided to use our powers under Section 31 of the Health and Social Care Act 2008 to take immediate enforcement action. We imposed additional conditions on the provider's registration in the form of a Notice of Decision. The conditions were to restrict the provider from admitting any new patients to Priory Barnt Green without the prior written agreement of the Care Quality Commission and to ensure they updated us daily about the discharge of existing patients.

The hospital communicated with families after we had completed our inspection that they had decided to close the hospital.

This was the first time we rated this service. We rated it as inadequate because:

- The service did not have a good track record on safety. Staff did not always keep patients safe from avoidable harm. Patients had been able to harm themselves when staff should have been keeping them safe.
- The service did not have enough nursing staff and relied on agency staff. There were occasions where there were not enough nurses on shift. Patients and staff had concerns about the way agency staff treated patients and worked. Agency staff did not have access to the clinical records system, this meant it was hard for them to access information
- Not all areas of the seclusion room where patients were placed for safety were visible to staff.
- Not all staff had the right experience or skills for their roles. Most support staff had not worked in a mental health setting previously. Staff turnover and performance issues were high. Staff did not receive regular supervision and a number of staff had not received training to keep themselves and patients safe in a timely way. Staff assessed risks to patients but did not always manage risks to patients well. Staff sometimes struggled to manage patients' challenging behaviour.
- There was not a full range of treatment and care plans for patients based on national guidance and best practice. Patients did not have access to enough individualised activity or psychological interventions.
- Staff did not always complete and record physical health observations of patients. The physical health of patients was not monitored regularly. Physical observations were not always completed or recorded after incidents of patients receiving rapid tranquillisation or patients head banging.
- Staff did not report all incidents and there had been delays in reporting, reviewing and investigating incidents. The service did not always manage incidents well and did not consistently learn from incidents to stop them reoccurring.

# Summary of findings

- Governance processes did not operate well, and this affected how the service managed risk and engaged with staff. The service had not always notified the CQC of incidents that they were required to. Record keeping was not consistent and there were gaps in documentation, including handover records, and Mental Health Act paperwork where information was missing or incorrect. Audits were not effective and staff meetings did not take place regularly.
- Not all patients felt staff always treated them kindly or respected their privacy and dignity. Not all patients felt all staff supported them with their care. Patients did not have discharge plans and did not have regular one to one sessions with their named nurse. The service had not ensured that patients could access independent advocates. Carers did not feel well informed.

The Chief Inspector of Hospitals is placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Acute wards for adults of working age and psychiatric intensive care units** | Inadequate  | The summary is contained in the overall summary at the beginning of the report. |

# Summary of findings

## Contents

# Summary of this inspection

## Background to Barnt Green

We carried out this inspection of Priory Hospital Barnt Green in line with our inspection methodology for newly opened services. The hospital opened in February 2021 and at the time of our inspection there was one ward open. The hospital had plans to open another two wards and were in the process of recruiting staff for one of these wards.

We inspected Bittell ward, this is a ten-bed female psychiatric intensive care unit.

The Priory Hospital Barnt Green hospital is provided by the Priory Group.

The hospital provided the following regulated activities:

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

At the time of our inspection there were nine patients on Bittell ward.

# Summary of this inspection

**What people who use the service say**

We spoke to four patients during our inspection. Feedback from patients was mixed. One patient shared information about specific incidents where staff had not acted to keep them safe. Two patients told us staff slept when they were meant to be observing the patients to keep them safe. Three patients told us there was insufficient activity. Two patients said there were not always enough staff and they did not have regular one to one time with their named nurse and one patient said they did not know who their named nurse was. Patients told us they did not feel listened to by staff and two patients said that they found staff attitudes mixed, some staff were polite, but others were rude and not engaged. Those patients we asked told us they had a copy of their care plan.

Patients told us they did not always find it easy to access a drink as hot and cold drinks had to be requested from staff and staff were often busy.

We asked the provider if we could speak to families and carers about their views on the service. The provider gained consent from two family members. Both family members said they did not think the patients were safe from other patients, that communication with staff was poor, and that there were insufficient activities. One family member said staff did not have a good attitude, the other said they had not been informed when their daughter was assaulted.

One of the families thought their family member had made progress and their mental health had improved. They also said they had been involved in meetings and their opinions were sought. The other family told us their family member's behaviour had become worse since they had been at the hospital. They were unhappy there were no psychological interventions available and that the complaints process was not made clear to them. Both family members told us that they were not happy with the discharge arrangements after the hospital closure and the way the hospital had communicated with them about this. They did not think the hospital communicated with them well.

We spoke with advocates who had worked with the hospital. One advocate told us that the hospital had not communicated well with them and not all staff were aware of their role.

We left comments cards for patients to complete. One patient made comments that were positive about care and treatment from staff and the hospital environment. The other patient made both positive and negative comments about staff attitudes and said agency staff are not consistent in their care of patients and do not care for them well.

## How we carried out this inspection

Our inspection was an unannounced inspection of all key lines of enquiry. We completed two days of site visits.

The team that carried out this inspection of the hospital comprised a lead inspector, a second inspector, a Mental Health Act reviewer and a specialist advisor who was a nurse with experience of working in a psychiatric intensive care unit. An inspection manager supported the inspection off site.

During the inspection visit, the inspection team:

- visited Bittell ward at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with the hospital manager, director of clinical services and two ward managers
- spoke with ten members of staff including support workers, a nurse, occupational therapist, doctor and psychologist.
- spoke with four patients who were using the service and received two comments cards.

# Summary of this inspection

- reviewed eight care and treatment records
- spoke to two carers
- received feedback from the external pharmacist who worked with the service and the mental health act advocate that the service commissioned.
- looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.ukwhat-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 trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the service MUST take to improve**:

We told the service that it must take action to bring the hospital into line with legal requirements.

**Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 Staffing (1) (2) a**

- The provider must ensure there are sufficient qualified nurses on each shift.
- The provider must ensure all staff receive regular supervision and training for their role.

**Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe Care and Treatment (1) (2) a b c d**

- The provider must ensure staff carry out physical health observations regularly to monitor patients' health.
- The provider must ensure staff complete appropriate physical health observations after occasions of patient's head banging and incidents of rapid tranquillisation.
- The provider must ensure they recruit suitably experienced and skilled staff who are experienced for their roles. The service must recruit to nursing vacancies in order that the service reduces its reliance on agency staff.
- The provider must ensure that staff understand how to safely care for patients. Staff must be supported to complete therapeutic observations safely, manage the security of the ward environment and restricted and risky items that may be used by patients to self-harm.
- The provider must ensure that patients can be observed in all areas of the seclusion room by staff.
- The provider must ensure that all staff complete their Immediate Life Support training.

**Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance Regulation 17 (1) (2)a b c d**

- The provider must ensure staff report all required incidents, that these are reviewed by a manager, investigated and learning is shared with staff.
- The provider must ensure that all relevant notifications are sent to the CQC.
- The provider must ensure there are effective governance processes including effective audits to ensure the following:

# Summary of this inspection

1. All records recording activities of patient care are completed fully; including handover records, therapeutic observation records and physical health monitoring and consent to treatment forms.
2. Agency staff can log into the care records system to access and record information.
3. Staff meetings take place regularly.

**Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10 (1) (2) a**

- The provider must ensure that staff always respect the privacy and dignity of patients.

**Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 Person Centred Care (1) a b c**

- The provider must ensure that staff treat patients with kindness and listen to their views.
- The provider must ensure all patients have an individual discharge plan.
- The provider must ensure that there are adequate and appropriate psychological interventions available for patients.

**Action the service SHOULD take to improve:**

**Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 Person Centred Care 1) a b c**

- The provider should ensure that patients' one to one sessions with named nurses regularly take place.
- The provider should continue to ensure that patients can access drinks and snacks when required.
- The provider should ensure that there are enough activities for patients and that these meet patients' individual needs.
- The provider should review all blanket restrictions in place on the ward.
- The provider should ensure that patients can access an Independent Mental Health Act Advocate.
- The provider should ensure that carers are well informed and are given the opportunity to provide feedback.

**Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (1) (2)**

- The service should continue to ensure that staff have completed their physical intervention training before they start work on the ward.
- The service should consider their physical intervention training programme to check it fully skills staff for their role.
- The service should ensure that patients' risk management information is detailed and complete.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Acute wards for adults of working age and psychiatric intensive care units** | Inadequate | Inadequate | Requires Improvement | Requires Improvement | Inadequate | Inadequate |
| **Overall** | Inadequate | Inadequate | Requires Improvement | Requires Improvement | Inadequate | Inadequate |

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

Inadequate

| | |
|---|---|
| Safe | Inadequate |
| Effective | Inadequate |
| Caring | Requires Improvement |
| Responsive | Requires Improvement |
| Well-led | Inadequate |

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

Inadequate

**Safe and clean care environments**

**The ward was clean, well equipped, well furnished and well maintained. However, the ward environment was not safe in all respects.**

**Safety of the ward layout**

Staff completed and regularly updated thorough risk assessments of the ward areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards.

The ward had ligature reducing fixtures and fittings that meant potential ligature anchor points were reduced. Where there were potential ligature anchor points staff mitigated the risks to keep patients safe.

Staff had easy access to alarms and patients had easy access to nurse call systems.

**Maintenance, cleanliness and infection control**

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed most aspects of infection control policy, including handwashing. However, we did see two staff who were not bare below the elbow.

The provider carried out regular infection prevention control audits and acted when required. They followed best practice and guidance to reduce the spread of COVID-19.

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

Inadequate

**Seclusion room**

There were two seclusion rooms. The seclusion rooms did not allow for clear observation of all areas, there was a space at the side of the toilets where patient could not be easily seen through the viewing window. There had been a recent incident where a patient could not be seen whist in seclusion and had been at risk of self-harm. The seclusion rooms had two-way communication, a toilet and a clock.

**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 did not have enough nursing staff. The service relied on agency nurses. Staff received basic training, but this training was not always available to staff in a timely way. Staff did not always keep patients safe from avoidable harm.**

**Nursing staff**

There were not always enough qualified nurses on shift to keep patients safe. We reviewed staff rotas and saw that during the months of May and June 2021 there had been at least 11 shifts where had only been one qualified nurse on duty when there should have been two nurses on duty. This was 9% of the total shifts for these two months.

The service had a high level of qualified nursing vacancies. The service had nine qualified nurse vacancies, although four of these vacancies had been mitigated with the use of staff who had been recruited for other wards. There were also vacancies for a third ward manager.

The service relied on agency staff. Staff and managers told us that there were concerns issues with agency staff practice including attitude, attendance and unsafe practice. Patients told us agency staff did not always care for them as well as permanent staff. In May and June 2021, on average 49% of all staff on the ward were agency staff.

Managers made sure all agency staff had a full induction and understood the service before starting their shift.

The service had high turnover of staff. The service had recruited some staff who were not suitable for their roles. There had been 14 staff leavers in the three months prior to inspection. Three of these staff had their probation period terminated and six were under investigation before their employment was terminated. Staff and managers were concerned about staff not having enough experience. Nearly all support staff had no experience of working in a mental health ward and none of these staff had worked in a psychiatric intensive care unit. A manager explained they had now changed their recruitment requirements and asked support staff to have experience in mental health.

Managers supported staff who needed time off for ill health and sickness levels were on average at 3.8%. This was lower than the organisational average of 5.6%.

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

Inadequate

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. However, staff were not always available as planned.

The ward manager could adjust staffing levels according to the needs of the patients and increased staffing requirements for support workers. Agency staff were used for therapeutic observations of patients.

Patients did not have regular one to one sessions with their named nurse. Records showed two patients did not have a one to one session in June 2021 and six other patients only had one session. These should have taken place weekly.

The service now had enough staff on each shift to carry out physical interventions safely. Eighty five percent of staff were compliant with their Preventing and Managing Violence and Aggression training. However, there had been delays in this training being offered to 35% of staff. This meant there were a significant amount of staff had worked on the ward without the right training to keep themselves or patients safe. Staff told us this was training was completed over two days and was face to face. We were concerned this was an inadequate amount of face to face learning to ensure staff were competent.

Staff met for handover twice a day at the end of each shift. There was a 'flash meeting' each morning between Monday to Friday to discuss risk and incidents. Records of handovers for a week in June 2021 did not show staff shared all key information. Records were not always completed fully and were not always detailed. There was one day where no handover notes had been recorded and other days where there was more than one record with differing information. We attended a morning flash meeting and saw that information was shared but that there was only limited discussion of incidents that had taken place on the previous shift.

**Medical staff**

The service had 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**

At the time of our inspection staff had completed and were up to date with their mandatory training apart from Immediate Life Support training. There were three of seven nursing staff who had not completed this.

The mandatory training programme covered necessary training areas. Managers monitored mandatory training and alerted staff when they needed to update their training.

**Assessing and managing risk to patients and staff**

**Staff assessed risks to patients but did not always manage risks to patients and well. Staff sometimes struggled to manage challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. There were blanket restrictions on the ward, most of these were being reviewed as part of the provider's restrictive interventions reduction programme.**

**Assessment of patient risk**

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

Inadequate

Staff completed risk assessments for each patient on admission arrival, using a recognised tool, and reviewed this regularly, including after incidents. There were also visible risk alerts on the care records system. However, the risk management plan was not contained in the patient's risk assessment. We looked at eight risk assessments. There was a description of the patient's risk, but staff did not detail how they planned to manage it in seven of these. We did see that there was information about how to manage risk in the 'keeping safe' care plans however this was not detailed in all the plans and absent in one. This meant risk management information was not immediately accessible to less experienced staff or staff that did not work on the ward regularly.

**Management of patient risk**

Staff did not always prevent or reduce risks to patients. Managers told us that staff were not always experienced enough to manage incidents effectively. A manager talked about staff 'freezing' and not knowing what to immediately to do to manage incidents and provided a recent example of this where a patient had self-harmed. This was because the majority of staff the provider had recruited had not worked in a mental health setting before. Staff did not always reduce risks in the environment or respond quickly enough which meant incidents had taken place.

There had been a number of incidents where patients were being observed by staff and had self-harmed. Patients had been able to access and swallow restricted items whilst staff observed them. There had been hospital admissions due to patients swallowing items on the ward. These issues continued after we had inspected the hospital, raised concerns and the hospital had produced a plan of actions to keep patients safe.

Staff reported that there were issues with staff sleeping whilst they should have been observing patients, we saw incidents of this reported and there had been a recent occasion of self-harm that had taken place while staff were asleep.

We reviewed nine sets of therapeutic observation records and five of these were not completed fully. Staff did not record that they had observed patients when they should have done so. In addition, there had been incidents reported where staff had either not completed therapeutic observation records or completed them in retrospect.

We looked at a specific incident that staff had told us about where a patient had tied a ligature. We saw therapeutic observation records contained inaccuracies. The incident had not been investigated by managers despite there being a concerning account of this incident provided by staff. The provider was unable to investigate this incident when we raised concerns as a member of staff involved had left.

We raised immediate concerns about patients' self-harm at our inspection. The provider provided us with an action plan to ensure patient safety, However, patients continued to access restricted items and ligature tie to self-harm whilst being observed by staff and there were more incidents of staff sleeping whilst they were responsible for observing patients.

**Use of restrictive interventions**

There had been 12 episodes of seclusion and 103 occasions of restraint since the hospital opened in February 2021. Levels of restrictive interventions were appropriate for this kind of ward.

Staff had completed one search of the ward and three searches of patients' bedrooms since the hospital opened in February 2021. All patients were searched when they were admitted to the hospital. A manager told us all patients were searched each time they returned from leave. This was a blanket restriction but was not recorded as one or reviewed by staff.

There were other blanket restrictions on the ward. For example, doors to all communal rooms were locked and patients were not able to lock their bedrooms without asking staff. The provider had reviewed these as part of their reducing restrictive interventions programme.

Restricted items belonging to patients were stored under the patients' bed in a lockable drawer. However, after our inspection the provider changed this as patients had accessed restricted items. After our inspection, patient's belongings were kept in lockers in a separate locked room. The provider gave one member of staff access to this who was the security nurse. The provider decided to do this because there were incidents where patients had accessed restricted items and used these to self-harm. However, after the ward had made these changes there was another incident where a patient was able to access an item to self-harm from this locked room.

Staff avoided using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

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

There had been 34 occasions of rapid tranquillisation used since the service. Staff followed National Institute for Clinical Excellence guidance when they administered rapid tranquillisation.

We reviewed recent seclusion records and saw staff followed best practice guidelines.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

**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 received training on how to recognise and report abuse, appropriate for their role, 88% of staff were up to date with this.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

We saw that staff made safeguarding referrals and knew who to inform if they had concern and raised these with the local authority. However, we were not assured that this was completed in all cases based on our review of incidents.

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

Inadequate

**Staff access to essential information**

**Permanently employed staff had easy access to clinical information. It was easy for them to maintain clinical records – whether paper-based or electronic. This was not the case for agency staff.**

Agency staff could not log in to the care records system, so they could not access patients' records easily. Mangers told us they had requested log ins for agency staff two months ago. Agency staff had to ask other staff to log onto the system for them. They were unable to make notes on the care records system and did not have easy access to important information including risk information.

Records were stored securely.

**Medicines management**

**Medicines management**

**The service did not always use systems and processes to safely prescribe, administer and record medicines. Staff did not always review the effects of medications patient's physical health and did not consistently report medicines errors.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

The medicine cupboard and fridge were overstocked, and the medicine cupboard was disorganised. Staff told us this was because there was stock that belonged to a ward due to be opened stored in there temporarily.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, staff did not report local medicines errors consistently. A number of errors regarding medicines should have been recorded. There were 16 prescribing errors and 9 administration gaps that were discussed at a meeting, but only four had been reported.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff did not always review the effects of patient's medication used for rapid tranquillisation on their physical health in line with National Institute for Health and Care Excellence guidance. We reviewed 11 sets of records. Physical health observations were attempted post rapid tranquilisation and staff recorded when the patient declined. However, staff did not record level of consciousness or respirations when patients reviewed other elements of physical health observations. Managers did not audit physical health observations that took place after rapid tranquilisation

**Track record on safety**

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

Inadequate

The service did not have a good track record on safety. There had been a number of patient safety incidents where patients had been able to harm themselves whilst being observed by staff and sometimes patients had been able to access restricted items to do so. In addition, there were security issues including patients tailgating staff, and staff failing to lock doors or cupboards. We reviewed incidents and saw clear themes where patients had been able to endanger themselves whilst being observed by staff and that staff had made mistakes which meant patients could access objects to harm themselves. These types of incidents continued after we completed our inspection and the provider had put an action plan in place to reduce harm.

**Reporting incidents and learning from when things go wrong**

**The service did not manage patient safety incidents well. Staff had not always recognised and reported incidents. Managers had not always investigated incidents promptly and there were not consistent opportunities for lessons learned to be shared with the team so that changes could be made.**

Staff did not always report all incidents they needed to. Two serious incidents where patients had tied ligatures were discussed in a clinical governance meeting in April 2021 but only one of these was reported and was classed as having caused moderate harm. Managers had completed an audit of care records and identified several patient safety incidents that had not been reported. Not all medicine errors were reported, and staff did not report all incidents of short staffing.

There was a serious incident that had taken place where staff had informed the patient's family of what had taken place and demonstrated duty of candour.

Managers debriefed and supported staff after serious incidents. We saw debriefs had been recorded and staff told us about these. Staff also debriefed patients.

Managers had not always investigated incidents thoroughly and there had been a number of outstanding incidents that had not been reviewed in a timely way. There were 51 late entries recorded on the incident reporting system. The hospital had reviewed their processes and now reviewed incidents twice weekly.

Staff received some feedback from investigation of incidents, both internal and external to the service. However, staff did not have regular team meetings to look at internal improvements for patient care. The provider did not provide records to evidence that regular meetings took place where learning was shared. There were repeated incidents of patients who had self-harmed whilst being observed by staff. This demonstrated there was no evidence of regular feedback, learning and change being embedded.

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

Inadequate

Our rating of effective was inadequate.

**Assessment of needs and planning of care**

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

Inadequate

**Staff assessed the physical and mental health of all patients on admission but were not consistent in continued physical health monitoring of patients. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were mostly personalised, holistic and recovery-oriented.**

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission. There was a lack of clarity about how often staff should monitor patient's physical health. Staff used the National Early Warning Scores 2 (NEWS2) to do this and said they were meant to do this weekly, but this did not take place consistently. We reviewed NEWS2 charts for seven patients. No patients had monitoring completed every week and not all elements of the charts were completed, and none were scored.

We looked at two specific headbanging incidents and saw that staff did not complete neurological observations as described in the provider's policy and in National Institute for Health and Care Excellence 2019. Head Injury: assessment and early management CG176. We then reviewed 43 reported incidents of headbanging. Only four of these recorded that neurological or physical observations were completed.

Staff developed care plans for each patient that met their mental and physical health needs. All patients had care plans for keeping well, safe, connected and healthy. However, there were no specific discharge plans in place, these should have been started at the point of admission.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were mostly personalised, holistic and recovery orientated, although not all care plans were in the patient's voice.

**Best practice in treatment and care**

**Staff did not provide the full range of treatment and care for patients based on national guidance and best practice. Patients had access to physical healthcare and staff supported them to live healthier lives but did not have access to psychological interventions or enough activity. Staff did not use recognised rating scales to assess outcomes. Staff participated in clinical audit but not in benchmarking and quality improvement initiatives.**

Care was not delivered in line with best practice and national guidance. Not all aspects of care and treatment suitable for the patients in a psychiatric intensive care unit as set out in National Minimum Standards for Psychiatric Intensive Care in General Adult Services 2014. There was little evidence of activities consistently taking place on the ward. Even though there was an activity timetable, none of the planned activities took place on the days of our inspection. Patients did not have individualised activity timetables. Staff and patients told us there was not enough to do and we did not see evidence of regular activity in care records. We asked the provider for all their audits of activity. Audits were not completed consistently and for each patient. Several audits did not have patients' initials and so we could not review them. Audits indicated that there was some activity, but they did not provide evidence of patients regularly engaging with a personalised or structured activity programme.

Patients did not have access to psychological therapy. The psychologist provided psychological assessments and group reflective practice for staff, but no access to either one to one or group therapy for patients.

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

Inadequate

Staff identified patients' physical health needs and recorded them in their care plans.

Patients had access to physical health care, but two patients told us they needed to attend eye care appointments, and this had not happened.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives. There was a healthy lifestyle group and smoking cessation support.

Staff did not use recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. There was some limited evidence of The Health of the Nation Outcome Scores (HONOS) being used for care clustering but not to measure or assess progress.

Staff did not complete benchmarking and quality improvement initiatives. Audits took place and managers used results from audits to make improvements, but there was more work to be completed to ensure audits were effective.

**Skilled staff to deliver care**

**The ward team included specialists required to meet the needs of patients on the ward. However, managers did not think support staff had enough experience and the range of skills needed to provide high quality care. Supervision did not take place regularly. Managers provided an induction programme for new staff including agency staff.**

The service had specialists to meet the needs of the patients on the ward. There was a psychologist, consultant psychiatrist and speciality doctor. However, there was no social worker employed by the provider. There was an agency occupational therapist in position whilst the service recruited to a permanent role.

A manager told us that of the original 22 support staff recruited, 20 had not worked in a mental health setting and none of these staff had worked on a psychiatric intensive care unit. The provider had recently changed the way they recruited support workers and now asked for all staff to have previous experience of working in mental health. There were concerns from managers about the experience and skills level of support workers to be able to care for patients who required an intensive care environment.

Managers gave each new member of staff a full induction to the service before they started work. This included competency assessments.

As the service was new and most staff were in their probationary period appraisals had not yet been completed.

Where clinical supervision took place, it was of good quality, but supervision compliance was low at 45%. Supervision included both one to one and group supervision, which was provided by the psychologist.

Managers supported medical staff through regular, constructive clinical supervision of their work.

Staff meetings were not consistent and not recorded consistently. This meant that there were less opportunities for communication with staff.

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

Inadequate

In an aim to help staff develop who were new to this kind of work the service had developed scenario training, they did this to support staff to know how to respond to incidents. Staff had not completed specialist training in areas relevant to their patient group such as in specific physical health conditions or mental health presentations.

Managers recognised poor performance, could identify the reasons and dealt with these. There were several examples where managers had used the disciplinary process or dismissed staff.

**Multi-disciplinary and interagency teamwork**

**Staff from different disciplines worked together as a team to benefit patients. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.**

Staff held regular multidisciplinary meetings to discuss patients and improve their care. These took place weekly. The occupational therapist and psychologist attended these.

Ward teams had effective working relationships with other teams in the organisation and external teams and organisations.

**Adherence to the Mental Health Act and the Mental Health Act Code of Practice**

**Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them. However, consent to treatment forms were not completed correctly.**

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

The hospital did not have a permanent Mental Health Act administrator and therefore received support from another Mental Health Act Administrator from another local service. Staff had less access to support and advice on implementing the Mental Health Act and its Code of Practice.

Consent to treatment forms were not always completed correctly. There was missing information about a medicine that had been administered on one form and incorrect allergy information was on the other. During the first day of our inspection the provider's externally based pharmacist had identified further errors on two consent to treatment forms.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about non- independent advocacy and advocates. However, they did not have access to an independent Mental Health Act advocate. The local independent Mental Health Act advocates were not aware the hospital was open.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

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

Inadequate

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

**Good practice in applying the Mental Capacity Act**

**Staff supported patients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.**

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

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

Requires Improvement

**Kindness, privacy, dignity, respect, compassion and support**

**Not all staff treated patients with compassion and kindness and respected patients' privacy and dignity. Most staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.**

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

Inadequate

Patients told us that most staff respected their privacy and were respectful, but patients gave us two examples where this was not the case. We observed a male member of staff who did not knock on bedroom doors to alert patients to observation checks. Staff had left vistamatic blinds open despite patients being asleep and not having requested that they wanted their blind leaving open.

Most staff gave patients help, emotional support and advice when they needed it. Although some patients told us this was not always the case.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients gave mixed responses about how staff treated them. We spoke to four patients and received two comments cards. Overall patients said most staff treated them well and behaved kindly, but not all staff. Only one patient said was this the case for all staff.

Permanently employed staff understood and respected the individual needs of each patient, but patients told us this was not always the case for agency staff.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Most staff kept patient information confidential, but there were examples of staff who had not done this, the provider had acted in response to this issue.

**Involvement in care**

**Patients could feedback about the service and staff involved patients in care planning but not all patients felt listened to and actively engaged in their treatment. The service had commissioned their own advocates but had not ensured there was access to independent advocates.**

**Involvement of patients**

Staff introduced patients to the ward and the services as part of their admission. However, the hospital did not have a pack with information about the ward specifically for patients.

Staff involved patients and gave them access to their care planning and risk assessments. Those patients we asked told us they had seen their care plans. Three patients said they did not always feel listened to by staff.

Staff made sure patients understood their care and treatment

Patients could give feedback on the service and their treatment and staff supported them to do this. this was done through community meetings, although two patients said that the service was slow to action change.

There were no advanced decision in place for patients at the time of our inspection.

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

Inadequate

The provider commissioned advocacy services, but patients did not have access to independent mental health advocacy services. The local independent advocates had not been contacted by the hospital and were not aware of the service provided.

**Involvement of families and carers**

**Carers did not think staff always kept them informed and had not been asked for feedback.**

Carers that we spoke to did not always feel well informed.

The service had not asked families to give them feedback on the service, they told us they planned to do this.

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

Requires Improvement

Our rating of responsive was requires improvement.

**Access and discharge**

**Staff managed beds well. Discharge was rarely delayed for other than clinical reasons.**

**Bed management**

Managers made sure bed occupancy did not go above 85%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Staff did not move or discharge patients at night or very early in the morning.

**Discharge and transfers of care**

The average length of stay was 52 days, this was ten days more that the provider aimed for but in overall the provider discharged patients within six weeks.

Managers monitored the number of delayed discharges. Discharge was sometimes delayed because of a lack of suitable beds on acute wards.

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

Inadequate

Staff planned patients' discharge and worked with care managers and coordinators to make sure this went well. However, patients did not have discharge plans. Discharge conversations were sometimes recorded in patient's care records.

Staff supported patients when they were referred or transferred between services. The service followed national standards for transfer.

**Facilities that promote comfort, dignity and privacy**

**The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality, but patients were restricted from making hot and cold drinks and snacks.**

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions. They had a locked cupboard in their bedroom.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private. There was a ward phone available.

The service had an outside space that was open and accessible to patients.

Patients could not have a snack or hot or cold drink without asking staff because the patient kitchen was locked. A manager told us that this should not have been the case and patients should have had access to cold drinks and snacks without needing to ask permission. This was changed when we asked about this. Three patients told us they could not have a drink straight away unless they were being observed by staff as staff were not available.

The service offered a variety of good quality food. Patients told us they were happy with this.

**Patients' engagement with the wider community**

**Staff supported patients with activities outside the service, such as work, education and family relationships.**

Staff helped patients to stay in contact with families and carers. We saw that staff encouraged communication with family and recorded when this had happened

Staff encouraged patients to develop and maintain relationships.

**Meeting the needs of all people who use the service**

**The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, cultural and spiritual support.**

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

Inadequate

The service made adjustments for disabled people and those with communication needs or other specific needs. There was readily available information for staff about accessible communication.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. There was information displayed throughout the ward.

The service had could access information leaflets available in languages spoken by the patients and local community. Managers made sure patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients told us the food was good quality and there was plenty of choice. Patients had access to spiritual, religious and cultural support. There was a faith room available.

**Listening to and learning from concerns and complaints**

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

Patients, relatives and carers knew how to complain or raise concerns. However, of the two carers we spoke to one did not think their concerns were dealt with well.

The service clearly displayed information about how to raise a concern in patient areas. This was in the main lounge.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. They knew where to find guidance about this.

Managers investigated complaints and identified themes. We saw evidence of a formal complaint where this took place. The service reported that one complaint had been made since the service opened.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Two patients told us there were no changes made in response to complaints they made verbally, and they could not make a formal complaint as no pens were allowed on the ward. However, patients did raise concerns in community meetings and staff responded to these complaints.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers made sure staff and patients could get help from interpreters or signers when needed.

The service used compliments to learn, celebrate success and improve the quality of care.

## Are Acute wards for adults of working age and psychiatric intensive care units well-led?

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

Inadequate

Inadequate

**Leadership**

**Not all leaders had the skills, knowledge and experience to perform their roles. However, they understood the service they managed and were visible in the service and approachable for patients and staff but were not experienced at working in a psychiatric intensive care unit environment.**

Some leaders had the skills, knowledge and experience to perform their roles. However not all managers had prior experience of working in a psychiatric intensive care unit. Leaders could tell us about the service and explain where they thought there were areas for improvement and what they were doing well. Leaders' main concern was about the inexperience of support staff.

Leaders were visible in the service and approachable for patients and staff. Ward managers worked in staff numbers and the clinical services director spent time on the ward.

Leadership development opportunities were available for managers. A ward manager had been given an opportunity to engage in leadership training.

**Vision and strategy**

**Staff knew and understood the provider's vision and values and how they were applied to the work of their team.**

Staff knew and understood the provider's vision and values, and these were visible to staff.

Staff had some opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. However, staff meetings were not consistent and were not recorded consistently.

**Culture**

**Staff felt respected, supported and valued. The service promoted equality and diversity in daily work and provided opportunities for development and career progression. Staff could raise concerns without fear.**

Overall, staff we spoke to felt respected, supported and valued and positive about working for the provider and their team. Some staff told us there had been an improvement in team relationships.

Staff felt able to raise concerns without fear of retribution and knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. There was readily available information about the Speak up Guardian. The hospital manager told us staff came to them to talk about the service and raise concerns.

Managers dealt with poor staff performance when needed. There had been several issues with staff performance. Staff reported that teams worked well together and where there were difficulties managers dealt with them appropriately.

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

Inadequate

The provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. However, we were told by a staff member that their COVID-19 risk assessment did not include consideration of potentially increased risk due to their ethnicity.

The service's staff sickness and absence were below the provider the provider target.

Staff had access to support for their own physical and emotional health needs through an employment assistance support programme.

The provider recognised staff success within the service. For example, staff were put forward for employee of the month programmes.

**Governance**

**Our findings from the other key questions demonstrated that governance processes did not always operate well, and this affected how the service managed risk and engaged with staff.**

The provider did not assure patients' safety, there had been a number of patient safety incidents and lapses in governance meant:

Despite this being a new staff team and staff not having come from a background of working in a mental health setting supervision compliance was low at 45%.

Incidents were not always reported in a timely way and there were several examples of incidents had not been recorded at all. Similar incidents happened on more than one occasion, this meant that learning and provider actions to reduce incidents happening again was not embedded.

There was a framework for ward staff meetings and clinical governance meetings, but staff meetings did not always take place. This was a missed opportunity for learning from incidents and team communication.

Clinical governance meetings took place, but staff meetings did not take place regularly. This meant there were less opportunities for sharing information, communication and learning from incidents.

Staffing was not managed well. The service relied heavily on agency staff. Support staff that had been recruited were not always experienced enough to work with the patient group. There were not always enough nurses on shift.

Clinical audits took place but were not always effective or completed. There were gaps in records that had not been rectified through the clinical audit process, as a result records were not always complete and accurate. These records included patients' therapeutic observation records, physical health monitoring and reporting of incidents.

Recruitment processes were not effective. There were a significant number of staff recruited who did not have enough experience to support patients in the environment of a psychiatric intensive care unit. There had been several unsuitable staff who had been dismissed from their roles during their probation period; staff turnover was high.

Training to keep staff and patients safe was not always offered to staff in a timely way.

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

Inadequate

**Management of risk, issues and performance**

Not all staff had always have access to the information they needed to provide safe and effective care and used that information to good effect. Agency staff could not access the care records system.

Staff had access to the risk register at ward or provider level. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register. For example, staffing vacancies.

The service had plans for emergency situations.

The service did not have cost improvements taking place.

**Information management**

**Staff collected analysed data about outcomes and performance.**

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. Including the performance of the service, staffing and patient care.

Staff did not always make notifications to the CQC when required to. The provider had failed to notify us of all notifiable incidents. We reviewed incident records and saw that there were two occasions where there had been police incidents and the provider had failed to notify us of at least ten other incidents which should have been raised as a safeguarding notifications which the provider had not informed us of.

**Engagement**

**Managers did not engage with all relevant local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of patients.**

Patients and staff received updates about the service, although the two carers we spoke to did not feel well informed.

Patients had opportunities to give feedback on the service they received individually or at community meetings, although not all patients thought they were listened to. Carers had not been given the opportunity to feedback through carer surveys, but the service had planned to do this. Managers and staff had access to the feedback from patients and staff and had used it to make improvements.

Staff could meet with members of the hospital manager to give feedback and had done so.

Leaders engaged with external stakeholders – such as NHS trusts that commissioned beds. However, they had not liaised with local commissioners or the local independent advocacy service. Independent Mental Health advocacy was not aware of the service.

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

Inadequate

**Learning, Continuous Innovation and improvement.**

There were no staff involved in research at the time of our inspection or innovations taking place

There was no formal quality improvement activity taking place at the service.

The service was not involved in any national accreditation schemes or participation in national audits.

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<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>**The provider had not ensured there were sufficient qualified nurses on each shift.**<br><br>**The provider had not ensured all staff regular supervision and training for their role.**<br><br>**Regulation 18 Staffing (1) (2) a** |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>• The provider did not ensure that all staff treated patients with kindness and listen to their views<br>• The provider did not ensure all patients had an individual discharge plan.<br>• The provider did not ensure that there were adequate and appropriate psychological interventions available for patients.<br><br>**Regulation 9 (1) a b c** |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>• The provider did not ensure that staff always respected the privacy and dignity of patients.<br><br>**Regulation 10 (1) (2) a** |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>• The provider did not ensure staff always carried out physical health observations regularly to monitor patients' health.<br>• The provider did not ensure all staff completed appropriate physical health observations after occasions of patient's head banging and incidents of rapid tranquillisation.<br>• The provider did not ensure they always recruited suitably experienced and skilled staff who are experienced for their roles.<br>• The provider did not ensure all staff understood how to safely care for patients.<br>• The provider did not ensure that all patients could be observed in all areas of the seclusion room by staff.<br>• The provider did not ensure that all staff completed their Immediate Life support training.<br><br>**Regulation 12 Safe Care and Treatment (1) (2) a b c d** |

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>• The provider did not ensure all staff reported all required incidents, and that these were appropriately reviewed, investigated and learning shared with staff.<br>• The provider did not ensure all relevant notifications were sent to the CQC.<br>• The provider did not ensure there were effective governance processes including effective audits.<br><br>**Regulation 17 (1) (2)a b c d** |