Priory Healthcare Limited

Woodbourne Priory Hospital

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?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

Woodbourne Priory Hospital is owned by the Priory which merged with Partnerships in Care in November 2016. Woodbourne Priory Hospital is registered to provide care and treatment to children, young people and adults with mental health conditions, including those whose rights are restricted under the Mental Health Act. This was a focussed inspection in response to the publication of the prevention of future deaths document that was created after the coroners hearing into the death of a service user at the service in September 2020

Our rating of this service went down:

- The service did not always provide safe care. Staff assessed and managed risk but not always responsively.
- Governance systems put in place following a serious incident had not been fully embedded and we found systems to responsively capture and mitigate risks were failing.
- There were inappropriate admission onto Acer Ward, which was designated by the hospital as a community facing ward. We were told that admissions to Acer ward would be limited to transfers from more restrictive areas of the hospital as patients recovered and specific spot purchased beds for patients that presented lower risks. When we reviewed recent admissions we established that some patients had been admitted from the community directly onto the ward that did not fit the admission criteria of low risk.
- The majority of actions from independent and internal investigations had been addressed. However, there was still work ongoing to address some of the environmental issues that had been identified. Work was ongoing to address groundwork in the garden area of Beech Ward.

However:

- The management team were responsive to concerns and responded quickly to information brought forward at the coroner's inquiry and from the CQC inspection.
- The daily 'flash' meetings allowed for an early review of incidents and the opportunity for lessons to be shared.

We served the provider with a letter of intent under Section 31 of the Health and Social Care Act 2008, to warn them of possible urgent enforcement action. We told the provider we were considering whether to use our powers to urgently impose conditions on their registration. The effect of using Section 31 powers is serious and immediate. The provider was told to submit an action plan within a short timescale that described how it would address our concerns. The provider's response provided enough assurance they had acted to address immediate concerns and we therefore did not progress with urgent enforcement action at that stage.

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 	Acute wards for adults of working age and psychiatric intensive care units • Maple, Beech and Acer wards are mixed gender acute wards for adults and have 37 beds. • Aspen Ward a male-only psychiatric intensive care unit and has 10 beds.
Child and adolescent mental health wards	Inadequate 	Child and Adolescent mental health wards: • Mulberry Ward is a mixed gender inpatient child and adolescent mental health ward with 14 beds.
Specialist eating disorder services	Good 	Specialist mental health eating disorder services • Oak Ward a female-only specialist eating disorder ward for adults of working age and has nine beds.
Long stay or rehabilitation mental health wards for working age adults	Good 	Long stay or rehabilitation mental health wards for working age adults • The Manor is a private adult mental health and addiction therapy ward and has nine beds. The Manor also offers an aftercare programme for patients who have completed the inpatient service.

Summary of findings

Contents

Summary of this inspection

Background to Woodbourne Priory Hospital

Woodbourne Priory Hospital is owned by Priory. Woodbourne Priory Hospital is registered to provide care and treatment to children, young people and adults with mental health conditions, including those whose rights are restricted under the Mental Health Act. The service is registered to provide the following regulated activities:

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

The service comprises seven wards. The wards included:

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

- Maple, Beech and Acer wards are mixed gender acute wards and have 37 beds.
- Aspen Ward a male-only psychiatric intensive care unit and has 10 beds.

Child and Adolescent mental health wards:

- Mulberry Ward a mixed gender inpatient child and adolescent mental health ward with 14 beds.

Specialist mental health eating disorder services

- Oak Ward a specialist eating disorder ward for adults of working age and has nine beds.

Long stay or rehabilitation mental health wards for working age adults

- The Manor is a private adult mental health and addiction therapy ward and has nine beds. The Manor also offers an aftercare programme for patients who have completed the inpatient service.

At this inspection – all wards were visited to gain assurance that concerns arising from a recent coroners' inquiry had been fully addressed and risks mitigated.

The Care Quality Commission carried out a comprehensive inspection of Woodbourne Priory Hospital in October 2021 and the overall rating was good. Safe was rated Requires Improvement for the acute wards for adults and psychiatric intensive care unit and wards for children and adolescents core services. This meant that the aggregated rating for Safe was also Requires Improvement. The service had received two requirement notices in relation to Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment and one in regard to Regulation 18 HSCA (RA) Regulations 2014 Safe Staffing:

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

- The provider must ensure that ligature risk assessments are undertaken and updated, and any identified risks must be eliminated or mitigation plans must be developed that are available for all staff to read. (Regulation 12).

Child and adolescent mental health wards

Summary of this inspection

- The provider must ensure that there are sufficient numbers of staff of the correct grades to cover all shifts. (Regulation 18).

Long stay or rehabilitation mental health wards for working age adults

- The provider must ensure the ward complies with policy on children visiting the ward. (Regulation 12).

There was no CQC registered manager in post at the time of our inspection. An interim manager had been appointed to cover the period between the last manager leaving and the appointment of a new manager. The new manager had been appointed and was due to take up their post the same week as we undertook our inspection.

This inspection was a responsive focused inspection looking at elements of the safe and well led key lines of enquiry. The reason for this inspection was the receipt of a Regulation 28 Prevention of Future Deaths report from the Birmingham coroner. The coroner had highlighted five areas of concern impacting on the safe care of patients and contributory to the death of a patient in September 2020.

A Regulation 28 Report is not just a record of historic concerns related to the death, it is a court record of current serious concerns. Regulation 28 reports contain important and credible intelligence for CQC and we focused on the five matters of concern highlighted for action by the Priory Hospital. These were record keeping, record keeping quality, risk assessments, serious incidents and the security of the courtyard fences

How we carried out this inspection

The inspection team visited on four days and was made up of one inspection manager and two inspectors. The first visit to the hospital was unannounced.

- visited all wards;
- spoke with the senior managers of the service
- spoke with four ward managers;
- spoke with 24 staff members including nurses, support workers;
- reviewed incident records for the service in the previous year;
- looked at 18 care and treatment records for patients;
- examined 35 handover records for concordance with current risk information;
- spoke with one commissioner;
- attended meetings specific to patient care and the running of the service;

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

The main service provided by this hospital was acute wards and psychiatric intensive care wards for adults. Where our findings on acute wards and psychiatric intensive care wards for adults – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the acute wards and psychiatric intensive care wards for adults service.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action the service 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:

- The service must ensure that changes in the process to ensure a responsive review of incidents are fully embedded in practice and the ongoing monitoring and mitigation of risks to service users are under the review of the clinical leadership on site and subject to regular audit and review. (Regulation17)
- The service must ensure that risk assessments and management plans are reviewed and updated following incidents or changes to identified risks. (Regulation 12)

Action the service SHOULD take to improve:

- The service should consider a consistent process across all wards to produce handover information from current care records (Regulation17)
- The service should continue to ensure that patients transferred to Acer ward are appropriately risk assessed and meet the admission criteria for the ward.

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	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Child and adolescent mental health wards	Inadequate	Not inspected	Not inspected	Not inspected	Requires Improvement	Inadequate
Specialist eating disorder services	Good	Not inspected	Not inspected	Not inspected	Good	Good
Long stay or rehabilitation mental health wards for working age adults	Good	Not inspected	Not inspected	Not inspected	Good	Good
Overall	Inadequate	Good	Good	Good	Inadequate	Inadequate

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

Inadequate

Safe	Inadequate
Well-led	Inadequate

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

Inadequate

Safe and clean care environments

Ward gardens and courtyards were safe, and had been recently risk assessed.

Safety of the ward layout

Staff had completed thorough risk assessments of six or the seven outside (garden and courtyard) areas of the seven wards, and removed or reduced any risks they identified.

The provider had updated their garden and courtyard risk assessments following concerns raised during the Coroner's inquiry. As a result of additional concerns raised regarding the safety of the courtyard on 15 April 2022 the provider had revised their national courtyard risk assessments.

This had been shared with all hospitals in the Priory mental health division on 4 May 2022. Returns for all wards at Woodbourne Priory were completed by 9 May 2022 and forwarded to the CQC for review. We found the revised assessments for six of the seven wards to be comprehensive of known risks and appropriate mitigation of risk had been put in place where required.

Staff could not directly observe patients in all outside areas of the wards without physically escorting patients. Staff knew about any potential ligature anchor points in the courtyard and garden areas and mitigated the risks to keep patients safe. Staff undertook individual patient risk assessments and supervised patients in outside areas where this was deemed necessary.

We reviewed the garden and courtyard areas of each ward and discussed with staff how they observed patients using the space.

Aspen ward was designated as a Psychiatric Intensive Care Unit (PICU), its outside space was consequently more secure than the other wards. The outside area was surrounded by a high fence and additional precautions to prevent anyone climbing out of the area. A second smaller courtyard allowing outdoor access for patients in seclusion was similarly secure.

The courtyard area on Beech ward was closed at the time of our inspection. Work was due to start to excavate part of the floor of the courtyard to create a level area, removing steps and effectively increasing the height of the fence. Patients from the ward were able to access outside spaces in the main gardens of the hospital under escort

On Maple ward the outside area was flat and surrounded by a high fence. Access was allowed only with staff supervision.

However, on Acer ward which was a community facing ward. On the basis of a personalised risk assessment some patients on this ward had been given unescorted access to the garden and courtyard area. We were concerned that the distance from the ward, lack of sufficient CCTV coverage and lack of a specific risk assessment of the garden and courtyard area that the risks of self-harm and or absconding had not been appropriately assessed. The courtyard risk assessment for this ward was reviewed as a result of our feedback and patients were required to have an escort when using this area in the future to reduce the risk of self-harm and absconding.

. Assessing and managing risk to patients and staff

Staff had not always assessed and managed risks to patients and themselves well. Risk assessments did not always reflect current known risks.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, which defined an initial safety patient plan but had failed to review these regularly after any incident.

However, we also identified a concern relating to a patient admitted directly to Acer ward from a community setting.

Acer Ward had opened since the previous inspection in October 2021. It was a community facing ward focused on providing a pathway to a less restrictive environment for patients ready to move on from the two acute wards (Maple and Beech). It also took direct admissions from commissioners through a spot bed purchase scheme. This arrangement relied on the agreement of the duty manager to agree an admission based on a referral from the commissioner. However, we were not assured that the lower risk threshold described as one of the admission criteria was well defined. We observed at an evening handover the report of the admission direct from an acute hospital where risks had not been clearly assessed as low. Subsequently, due to our feedback on the inspection, the patient was transferred to one of the acute wards overnight.

Further information was requested from the provider and assurances were received that processes were in place to guarantee the safety of patients. A request made to suspend direct admissions to the ward was met.

In addition to the incident identified at our inspection, one earlier incident was reported by the provider where there was a direct admission to the ward from a community setting. Following the inspection, the provider told us it had refreshed the existing policy and reinforced to staff across the hospital that all admissions to Acer ward are to come from an existing in-patient placement at the hospital or another acute service.

Management of patient risk

Staff did not always know about any risks to each patient or acted to prevent or reduce risks.

Staff had failed to identify and respond to any changes in risks to, or posed by, patients.

The coroner's inquest found that a failure to maintain up to date risk assessment remained a current concern in the prevention of future deaths notice published on 22 April 2022. This followed an action plan agreed by the provider in January 2021 to make improvements to risk assessments.

We reviewed 11 recent incidents recorded on the local DATIX reporting system.

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

Inadequate

On Aspen ward we reviewed five incidents and found that risk assessments and care plans had been updated in only two cases, one within 24 hours of the incident and one within 48 hours. All three incidents without updates referenced verbal aggression to staff and additionally in one case damage to property and use of seclusion. This posed a risk that staff working with patients were not fully aware of the risks that the patients may pose to themselves and others, or how to mitigate against such risks.

On Maple ward we reviewed four incidents and found risk assessments updated alongside care plans in two cases, one within 24 hours and one within 48 hours of the incident. One out of four care plans had also been updated, but without a corresponding update to the risk assessment.

On Acer ward we reviewed one incident and found no update to risk assessment or care plan.

Across the acute wards and PICU core service 11 incidents were looked at, in five cases risk assessments were updated, three times within the same day, on one further occasion within 48 hours and once after 48 hours. Five care plans had also been updated but not overlapping wholly with the updates to risk assessments.

Overall we found the approach to updating risk assessments and care plans to be inconsistent. In three cases we viewed the failure to update risk assessments produced an inaccurate record of known risks. This resulted in an assessment of low risk despite the incidents representing trends of increasing risk.

The delays and omissions in recording and recognising changes in risk increased the potential risk of harm to patients as there was no responsive risk mitigation and care planning to minimise future risk. As all the wards concerned care for people with acute mental health problems where risk is expected to be very dynamic this was a significant failing and threat to patient safety. This was also a repeated failing from the concerns identified by the Coroner.

We set out our concerns to the provider in a letter of intent under Section 31 of the Health and Social Care Act 2008, to warn them of possible urgent enforcement action on 17 May 2022 requesting a response within 24 hours. The provider responded by introducing a new review system at the morning flash meeting to ensure that all incidents are reviewed at the latest the next day. Any updates to care plans and risk assessments required are allocated to a clinician and checked as completed at the following days flash meeting. This provided assurance that updates were made at the latest 48 hours of any incident. We monitored this new system for a week to ensure the full range of risks were being captured.

Significant incidents of risk were now reviewed within the time of the shift they occurred by a senior clinician and there was early communication of the incident and immediate actions, such as raising observation levels, at ward handover.

We observed two handovers, one on Beech ward and one on Aspen ward and found that information was up to date in reporting incidents and activities on the previous shift and the most recent assessment of risk level and observations was handed over. Handover information on all four wards contained the same information.

In planning leave from the hospital, staff carried out a further risk assessment. We found these to be comprehensive and completed with a review of the patients' mental state before leaving the ward, details for contact and identification if the patient did not return from leave as planned. In our interviews with staff, the procedures around leave and providing an escort to patients were well understood and all staff knew how to report a patient not returning on time or absconding if escorted.

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

Inadequate

Staff access to essential information

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

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff could readily access records for the ward they were working on if only temporarily.

Records were stored securely.

Reporting incidents and learning from when things go wrong

The service reported patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support. However, we identified delays in recognising the impact of incidents on risk assessments that could leave patients at risk.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with provider policy.

Staff reported serious incidents clearly and in line with provider policy.

The service had no never events on any wards.

Managers investigated incidents. Patients and their families were involved in these investigations. We reviewed five incident reports that had been completed after 24 and 72 hours, which contained clear evidence of immediate actions.

Staff met to discuss the feedback and look at improvements to patient care.

We approached the director of clinical services to raise concerns about Acer ward in relation to management of their outside space. The director of clinical services quickly organised a team incident review with all ward mangers and their deputies. The purpose was to brief all managers involved in the on-call system who would make admission decisions. This meeting discussed the revised admission criteria and operating policy for the ward.

There was evidence that changes had been made as a result of feedback. We found evidence that the provider had learned from incidents of patients leaving the unit by climbing over the fences. Lessons learnt was circulated to all staff and a change in practice introduced to reduce future risk. Work was undertaken to improve the safety of the courtyard areas after incidents which included the introduction of anti-climb measures and work was ongoing to lower raised garden areas in order that there was a consistent fence height around the garden areas. The frequency of patients leaving the unit through the garden and courtyard spaces had reduced as a result of such additional precautions being in place as a result of lessons learnt.

Following an external review of security, undertaken in March 2022, on the site recommendations made in regard to improving surveillance and locks to ease access in an emergency were being implemented.

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

Inadequate

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

Inadequate

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients, families and staff.

Leadership at the unit had been subject to change and there was no CQC registered manager in post at the start of our inspection. There had been an interim manager in post for two months prior to our inspection and a new substantive registered manager had been recruited and was taking up post the week we inspected. The director of clinical services was leading the service day to day. They received support from senior clinicians within the hospital and externally from a previous hospital director and members of the provider's regional and national leadership teams.

They had the skills, knowledge and experience to perform their role. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. A new hospital director joined the team during the inspection and was registering as a manager with CQC.

Governance

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Priory had refreshed its approach to clinical governance in 2021. It consolidated a clinical governance framework within each of the providers operational divisions. It provided a clear framework and model agendas, reporting templates and common terms of reference

The majority of actions from the independent and internal investigations had been addressed. However, there was still work ongoing to address some of the environmental issues that had been identified. Work was ongoing to address groundwork in the garden area of Beech Ward.

We found that admission criteria on Acer ward, a newly commissioned community facing ward did not adequately assure that risks could be effectively managed. Since the ward was effectively a step-down service from more restrictive environments, risk assessments for patients admitted to the ward needed to more robust. This was not possible when admitting patients from the community where hospital staff had not been involved in ongoing review of risk and care delivery. As such we found that there had been admissions to the ward that were not appropriate.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. However, we found that there were issues with the timely updating of risk assessments. We found that new risks were not always documented and an action plan had not always been developed at the time that a new risk was presented.

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

Inadequate

The hospital had a risk register which detailed the top risks to the hospital in recent times.

The hospital also maintained a site improvement plan, of which reports were sent to commissioners of NHS services as part of routine contract monitoring.

Staff were provided with daily and weekly updates on risk, performance, staffing updates and shared learning from incidents and complaints. As a result of issues identified with risk assessments at the time of our inspection, the hospital had implemented new systems to ensure that risk was assessed and managed in a timely way. A daily morning flash meeting of all ward managers was introduced where risk from all wards was discussed. There was also time given to update senior management of action plans that had been developed to manage new recent risks.

Inadequate

Child and adolescent mental health wards

Safe	Inadequate
Well-led	Requires Improvement

Are Child and adolescent mental health wards safe?

Inadequate

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

Safe and clean care environments

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

For more information, please see the report for Acute services for Adults of Working Age

Safety of the ward layout

We reviewed the garden and courtyard areas of each ward and discussed with staff how they observed patients using the space.

Mulberry ward courtyard was accessible and surrounded by a high fence on three sides with anti-climb features. Access was supervised by staff.

Assessing and managing risk to children and young people and staff

For more information, please see the report for Acute services for Adults of Working Age

Staff assessed and managed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

For more information, please see the report for Acute services for Adults of Working Age

Assessment of patient risk

Management of patient risk

Our sample of incidents included ten incidents on Mulberry (CAMHS) ward, in only two cases the care plan and risk assessment had been updated, in one case on the same day. In a further three cases, the care plans had been updated but without a corresponding update to the risk

Inadequate

Child and adolescent mental health wards

Handover information was up to date in reporting incidents and activities on the previous shift and the most recent assessment of risk level and observations was handed over.

Staff access to essential information

For more information, please see the report for Acute services for Adults of Working Age

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

For more information, please see the report for Acute services for Adults of Working Age

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

For more information, please see the report for Acute services for Adults of Working Age

Are Child and adolescent mental health wards well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children, young people, families and staff.

For more information, please see the report for Acute services for Adults of Working Age

Governance

For more information, please see the report for Acute services for Adults of Working Age

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Management of risk, issues and performance

For more information, please see the report for Acute services for Adults of Working Age

Good

Specialist eating disorder services

Safe	Good
Well-led	Good

Are Specialist eating disorder services safe?

Good

Our rating of Safe stayed the same. We rated it as Good.

Safe and clean care environments

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

The ward area was clean, well maintained and fit for purpose. There were no blind spots or other risks that had not been mitigated and there were environmental risk assessments in place.

Safety of the ward layout

Oak ward provided escorted access to the outside for higher risk patients. The outside area had been risk assessed and environmental risks mitigated.

Assessing and managing risk to patients and staff

We looked at 4 sets of patients records and found that there were risk assessments in place that were regularly reviewed and updated. they contained all relevant information.

Assessment of patient risk

Management of patient risk

Handover information was up to date in reporting incidents and activities on the previous shift and the most recent assessment of risk level and observations was handed over.

Staff access to essential information

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Good

Specialist eating disorder services

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy.

Are Specialist eating disorder services well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients , families and staff.

The ward manager had experience of working within an eating disorder service.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

We saw systems and processes were embedded on the ward to ensure there was effective oversight of areas including undertaking audits, incident reviews and shared learning.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. The ward did not have an individual risk register however there was a mechanism for the ward manager to add concerns to the hospital risk register.

Long stay or rehabilitation mental health wards for working age adults

Good

Safe	Good
Well-led	Good

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

Good

Our rating of safe stayed the same. We rated it as good.

Safe and clean care environments

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

The ward area was clean, well maintained and fit for purpose. There were no blind spots or other risks that had not been mitigated and there were environmental risk assessments in place.

Safety of the ward layout

The Manor had a higher proportion of patients likely to be informal. Individualised risk assessments determined the need for a staff escort. The outside area had been risk assessed and environmental risks mitigated

Assessing and managing risk to patients and staff

We looked at 4 sets of patients records and found that there were risk assessments in place that were regularly reviewed and updated. they contained all relevant information.

Assessment of patient risk

Management of patient risk

Handover information was up to date in reporting incidents and activities on the previous shift and the most recent assessment of risk level and observations was handed over.

Staff access to essential information

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy.

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

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients, families and staff.

The ward manager was experienced and had received training specific to their role.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

We saw systems and processes were embedded on the ward to ensure there was effective oversight of areas including undertaking audits, incident reviews and shared learning.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. The ward did not have an individual risk register however there was a mechanism for the ward manager to add concerns to the hospital risk register.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure that changes in the process to ensure a responsive review of incidents are fully embedded in practice and the ongoing monitoring and mitigation of risks to service users are under the review of the clinical leadership on site and subject to regular audit and review. (Regulation17)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure that risk assessments and management plans are reviewed and updated following incidents or changes to identified risks. (Regulation 12)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.