The Huntercombe Hospital - Roehampton

Quality Report

The Huntercombe Hospital Roehampton
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Date of inspection visit: 4 and 5 November 2019
Date of publication: 22/01/2020

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Inadequate
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

This was a focused inspection where we looked at the safe and well led domains. We carried out this inspection after anonymous concerns were raised with us and we received the outcome of recent safeguarding investigations. As a result of this inspection, our rating of safe domain went down from requires improvement to inadequate. Our rating of well led stayed the same and remains requires improvement. Our overall rating of this service did not change as a result of this inspection and remains requires improvement.

Due to concerns found during this inspection and the history of non-compliance over the last four years, we used our powers under section 17 of the Health and Social Care Act to propose the cancellation of the registration of this hospital location. The provider has the right to make representations about this proposal.

The areas for improvement identified at this inspection were as follows:

- High use of agency staff meant there was a risk that patients did not receive consistent and safe care. Seven registered nurses, out of a required establishment of 20, were employed by an agency. The hospital used agency staff to cover vacant posts and to support patients where their individual risks meant that enhanced observation was used. This meant that there could be significant numbers of agency staff working at any time. During our visit 75% of unregistered nurses (support workers) on Upper Richmond Ward at night were agency staff. This meant that there were staff frequently working in the hospital who did not know the wards or other staff. This impacted on the ability of the staff to work safely as a team to provide relational security.
- Wards were often noisy and there were frequent disturbances. One patient said they found the ward noisy and scary. Three patients said they had been assaulted by other patients. Patients had also expressed these concerns in community meetings and this was recorded in the notes of these meetings. We observed the wards to be noisy with frequent disruptions. This was also reflected in the records of incidents. Between 1 November 2018 and 20 November 2019, the provider notified the CQC of 140 allegations or incidents of abuse. There were eight notifications between 31 October and 6 November 2019. During this time, two incidents involved patients being slapped in the face in unprovoked attacks, three incidents of patients being punched in the face or head, one incident involving a fight between two patients and one incident of intimidating behaviour involving verbal and racist abuse. Data prepared by the hospital showed that between January and July 2019 there had been 80 assaults by patients on other patients and 56 assaults by patients on members of staff.
- The hospital was admitting patients with complex needs and then using high levels of enhanced observations. During our visit, on Upper Richmond ward, 20 staff were caring for 10 patients, seven of whom were on either 1:1 or 2:1 observations. This meant that the ward environment was very crowded and not therapeutic.
- There was more work to do to ensure that the use of restrictive interventions was being reduced as much as possible. The hospital did not have a restrictive interventions reduction programme, which had been recommended during our previous inspection in January 2019. The hospital was not benchmarking its use of restrictive interventions with similar services.
- Staff did not always use the correct techniques for restraining patients. Patients said they had been in pain during restraints. There had been three recent safeguarding investigations which concerned restraint being used inappropriately. These investigations found that some holds used by staff were not approved
- The service did not always manage patient safety incidents well. Managers investigated incidents, but the lessons learned were not shared with the whole team and the wider service. Actions from investigation reports were not always carried out.
- Staff did not always have easy access to clinical information. Agency staff did not have access to the electronic patient record or the electronic system for recording incidents. Some staff commented that it was

Summary of findings

difficult to absorb and retain the patient information that was shared verbally with them during shift handovers. Entries on patient care and treatment records were often quite brief.

- Systems and procedures to ensure the safe, effective running of the hospital were not robust. The hospital relied upon high numbers of agency staff to deliver services who did not have access to electronic recording systems, were not supervised and did not attend team meetings. An effective system to obtain feedback on agency staff performance was not in place.. On Upper Richmond Ward, there had not been a team meeting for almost five months. This meant that staff had not had the opportunity to discuss and learn from serious incidents and safeguarding investigations that had taken place during that time.
- There was more work for the provider to do to ensure that the culture on the wards at all times reflected the provider's vision and values. During the night, permanent non-registered nurses were taking the lead for setting the culture. Whilst we saw that they were working hard to model the provider's vision and values, safeguarding investigations in October 2019 indicated that a small clique of staff working in the hospital at night may have developed their own inappropriate culture.
- Whilst the hospital had robust systems to assess risk, weaknesses in governance frameworks, including the oversight of agency staff meant there was a potential risk that individual patient risks were not always managed or mitigated appropriately.

However:

- A new interim hospital manager had recently been appointed. They demonstrated a sound understanding of the services they managed, including the challenges and were implementing initiatives to improve the quality and safety of the service.
- Staff morale had recently improved. Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.
- All wards were clean, well equipped, well-furnished and well maintained.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service maintained a risk register which was shared with staff and matched their concerns. Staffing of the hospital was included on the risk register.

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Background to The Huntercombe Hospital - Roehampton

The Huntercombe Hospital – Roehampton is provided by Huntercombe (No 13) Limited. It is registered to provide the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Accommodation for persons who require nursing or personal care

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury.

The service provides 39 psychiatric intensive care (PICU) beds. Kingston Ward provided care and treatment for up to 14 male patients. Upper Richmond provided care and treatment for up to 14 female patients. A third ward on the hospital site, Lower Richmond, was closed at the time of our inspection.

We have inspected Huntercombe Hospital – Roehampton ten times since 2010. Reports for these inspections were published between March 2012 and August 2018. Since the CQC began rating services in 2015, the service has been rated as either requires improvement or inadequate. The service was placed in special measures between May 2018 and January 2019

The last inspection of this service was in January 2019. We rated the service overall as requires improvement. We rated the domains of safe and well-led as requires improvement. We rated effective, caring and responsive as good. We found two breaches of regulation. These were in relation to regulation 12 (safe care and treatment) and regulation 17 (good governance).

The registered manager had left their role four weeks before this inspection. A new interim manager had been appointed and was in post. They had made an application to become the registered manager.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, a CQC inspection manager and a specialist advisor with a professional background in nursing on psychiatric intensive care units.

Why we carried out this inspection

This was a focused, unannounced inspection looking at the culture, safety and leadership of the service after anonymous whistleblowing concerns were raised with us.

We did not review the areas for improvement and breaches of regulation highlighted in the previous inspection.

How we carried out this inspection

This was a focused inspection. During the inspection we asked the following questions:

- Is it safe?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location. This included information about safeguarding concerns, whistleblowing reports and statutory notifications.

During the inspection visit, the inspection team:

Summary of this inspection

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with eight patients who were using the service
- spoke with the hospital managers
- spoke with 21 other staff members; including a ward manager, nurses, and healthcare assistant
- attended and observed two hand-over meetings, two multi-disciplinary meetings and a site operations meeting
- Looked at 11 care and treatment records of patients and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

During this inspection we interviewed eight patients. Feedback from patients was mixed. Most patients spoke positively about permanent staff. They found many staff to be caring and supportive. However, some patients said that some members of staff were less helpful. Patients said they preferred to be cared for by staff they knew. Some also said they did not always feel safe on the ward. Four patients said they had been assaulted by other patients or were scared. Two patients talked about experiencing pain when being restrained.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate 

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

- Wards did not always provide safe, therapeutic environments. Wards were often noisy and there were frequent disturbances. Some patients said they had been assaulted by other patients and did not feel safe.
- High use of agency staff meant there was a risk that patients did not receive consistent and safe care. Seven registered nurses, out of a required establishment of 20, were employed by an agency. The hospital used agency staff to cover vacant posts and to support patients where their individual risks meant that enhanced observation was needed. This meant that there could be significant numbers of agency staff working at any time. During our visit 75% of non-registered nurses (support workers) on Upper Richmond Ward at night were agency staff. This meant that there were staff frequently working in the hospital who did not know the wards or other staff. This impacted on the ability of the staff to work safely as a team to provide relational security.
- The hospital was admitting patients with complex needs and then using high levels of enhanced observations. During our visit, on Upper Richmond ward, 20 staff were caring for 10 patients, seven of whom were on either 1:1 or 2:1 observations. This meant that the ward environment was crowded and not therapeutic.
- Restrictive interventions were regularly used in the hospital. Between January and July 2019, there had been 299 incidents of restraint. There had been 175 incidents of rapid tranquilisation, of which 156 involved staff using restraint to administer the medicine. At our last inspection in January 2019, we said the provider should introduce a programme to reduce restrictive interventions. The provider had made little progress towards doing so and was not benchmarking its use of restrictive interventions against similar services.
- Staff did not always use the correct techniques for restraining patients. Patients said they had been in pain during restraints. There had been three recent safeguarding investigations which concerned restraint being used inappropriately and that some holds used by staff were not approved.

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- The service did not always manage patient safety incidents well. Managers investigated incidents, but the lessons learned were not shared with the whole team and the wider service. Actions from investigation reports were not always carried out.
- Staff did not always have easy access to clinical information. Agency staff did not have access to the electronic patient record or the electronic system for recording incidents. Some staff commented that it was difficult to absorb and retain the patient information that was shared verbally with them during shift handovers. Entries on patient care and treatment records were often quite brief.

However:

- All wards appeared clean, well-equipped and well maintained.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.

Are services well-led?

Requires improvement

Our rating of well led stayed the same. We rated well led as requires improvement.

- Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level. This meant that performance and risk were not always managed well.
- Staff employed by agencies did not receive formal supervision or attend team meetings. They were not necessarily aware of the provider's values.
- Despite there being a reliance on agency staff to provide the service, there were no systems in place to monitor the performance and competency of these staff. The service was reliant on ad hoc reports from support workers to identify any concerns. This was not a robust, consistent system.
- The responsibility for cultural leadership on the wards and setting the right tone at night was falling to a small number of permanent support workers. This had not been recognised by the provider. This was not a robust and consistent approach. Whilst many support workers were caring, skilled and experienced, there was a risk that an inappropriate culture may prevail.
- Whilst most staff felt respected, supported and valued, staff had recently raised concerns about feeling unsafe and unsupported.
- There were limited opportunities for patients to give feedback on the service. The service did not have systems in place to support all patients to give feedback.

Summary of this inspection

- There had been no team meetings on Upper Richmond ward for almost five months. This meant that staff had not had the opportunity to discuss and learn from serious incidents and safeguarding investigations that had taken place during that time. De-briefing sessions after incidents were not recorded so information discussed could not be shared with other staff.

However:

- A new hospital manager had recently been appointed. They demonstrated a sound understanding of the services they managed, including the challenges and were implementing initiatives to improve the quality and safety of the service.
- Local leaders were visible in the service and approachable for patients and staff.
- Staff morale had recently improved. Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.

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

Requires improvement

Safe	Inadequate
Well-led	Requires improvement

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

Inadequate

SAFE

Safe and clean environment

Safety of the ward layout

For each shift, a member of staff on each ward was assigned to the role of security nurse. Ward layouts allowed staff to observe all parts of the wards. Throughout each shift, staff were present in the communal areas and along the bedroom corridors. On each ward, the nurses' office was situated at the centre of the ward. These offices had large windows that enabled staff to see the whole of the communal area and the bedroom corridors.

Staff were continuing to improve their mitigation of the potential risks from ligature anchor points. A ligature point is anything that can be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Each ward had completed an assessment of risks from ligature points. Staff had updated these assessments when actions had been completed. During the previous year, the service had replaced windows and fitted anti-ligature hinges on bedroom doors. The wards had also appointed support workers to the role of 'anti-ligature' champions to raise awareness of ligature risk amongst their colleagues. Agency staff received information about the location of ligature points during their induction. Staff kept ligature cutters in the nurses' offices. There was a sign in each office that clearly showed staff where the ligature cutters were kept. The risks associated with ligature points were included on the hospital's risk register.

The wards complied with guidance on eliminating mixed-sex accommodation. Kingston Ward only admitted male patients. Upper Richmond Ward only admitted female patients.

Staff had easy access to alarms and patients had easy access to nurse call systems. Nurses were issued with a personal alarm at the start of each shift. Patients could call for help using call buttons in all the rooms. There were enough staff on the wards who could respond quickly if patients needed assistance.

Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings and were well-maintained. Tables and chairs were specifically designed to minimise the risks of patients throwing them or breaking them to use as weapons. For example, each ward had two or three small tables with four fixed stools. These tables were attached to the floor. Comfortable chairs and sofas were heavy and very difficult to lift or move. Records of community meetings showed that patients had raised concerns about the cleanliness of the sofa on Upper Richmond ward. However, at the time of the inspection, all furniture appeared visibly clean.

Staff adhered to infection control principles, including handwashing. Staff received training on infection control as part of the organisation's mandatory training programme. Disinfecting gel dispensers were installed in the nurses' offices.

Safe staffing

Nursing staff

We found that insufficient consideration had been given to the staffing ratio between permanent and agency staff and the levels of patient acuity. This meant there was a potential risk that patients received inconsistent care that was not safe and did not meet their needs. We saw that at night wards were cramped, noisy and did not provide a therapeutic environment.

There were no vacancies for registered nurses. However. during our night time visit not all shifts were filled, which meant that there was only one registered nurse on duty on Upper Richmond Ward instead of the two registered nurses there should have been. The model of care provided by the hospital relied on the use of a flexible staff team that could increase or decrease each shift according to the needs and

acuity of patients. Whilst some bank staff employed by the hospital covered some shifts, the majority were filled by agency staff. During our night time visit 40% of non-registered nursing staff shifts were filled by agency staff on Kingston ward and over 75% of non-registered nursing shifts were filled by agency staff on Upper Richmond Ward.

Of the eight patients we spoke with, half told us they did not feel safe or had been assaulted by other patients during their admission. One patient said they found the ward quite noisy and scary. Three patients said they had been assaulted by other patients. During recent community meetings on Upper Richmond Ward one patient said the ward was noisy and violent and they were scared.

In September 2019, seven out of 21 registered nurses were employed by an agency. The service engaged these registered nurses employed by an agency on long-term contracts to ensure their consistency. Most of these nurses had been working at the hospital for approximately two years and felt they were a well-established part of the staff team. The hospital had seven vacancies for unregistered nurses out of an establishment of 40. This represents a vacancy rate of 18%.

Managers had calculated the number and grade of nurses and healthcare assistants required. The hospital operated two staff shifts each day. The day shift started at 8am and finished at 8.15pm. The night shift started at 8pm and finished at 8.15 am. The service allocated three nurses to each ward during the day. At night, the service allocated two registered nurses to each ward. The number of healthcare support workers was calculated according to the number and acuity of patients.

The number of nurses and healthcare assistants usually matched this number on all shifts. However, wards were occasionally understaffed if staff cancelled their shift at short notice, such as when they were unwell. During our inspection, there was only one registered nurse on the night shift on Upper Richmond Ward.

The ward managers could adjust staffing levels daily to take account of the case mix. Managers allocated staff to each ward depending on the observation levels for the patients. However, this meant there could be a lot of staff on each ward. For example, on the day shift of our inspection there were 20 staff on Upper Richmond Ward caring for ten patients. This number was based on there being three patients on two-to-one observations and four patients on one-to-one observations. During our inspection, the wards were often noisy and there were frequent disruptions. However, we observed that staff responded quickly and provided care and reassurance to patients who were distressed.

The model of care provided by the hospital relied on the use of a flexible staff team that could increase or decrease each shift according to the needs and acuity of patients. As a result, the hospital used a high number of non-registered nurses from employment agencies to ensure there were sufficient staff to carry out the required levels of observations. For example, during our inspection, six out of the 17 non-registered workers on the day shift on Upper Richmond Ward were employed by an agency. During the night shift, 14 of the 18 unregistered nurses were employed by an agency. On the night shift on Kingston Ward, four out of ten unregistered nurses were employed by an agency. The use of such high numbers of agency staff on each shift meant there was a potential risk that staff might not know the ward or other members of the team, which could impact on the quality of the relational security.

When the service deployed support workers employed by agencies, those staff received an induction and were usually familiar with the ward. Permanent staff provided all agency workers with an induction at the start of each shift. This included being shown around the ward and being informed of any risks, including the location of ligature risks. The shift co-ordinators paired agency staff with more experienced support workers. Agency staff all attended the handover meeting at the start of the shift where they received information about each patient. One agency support worker said they had been asked to arrive an hour early for their first shift, so they could receive a full orientation to the hospital. When managers requested staff from the agencies, they asked for staff with experience of working at the hospital or working in other psychiatric intensive care units. This meant that the same staff usually attended the hospital. However, nurses said that on some occasions, agencies had provided staff with no experience of working in psychiatric intensive care units. In these circumstances, permanent staff spent time supporting and encouraging the agency worker to help them understand the routines of the ward and the needs of patients.

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

Requires improvement

Permanent staff said that it could be difficult working with high numbers of agency staff. Patients said they preferred working with permanent staff and raised concerns about some agency staff.

Staff were present in communal areas of the ward at all times. Throughout the inspection, staff were with patients in the communal area. Staff spent time talking with patients and engaging in activities. For example, on the night shift on Kingston Ward staff and patients were completing a jigsaw puzzle together. Staff always responded promptly to patients needs and requests.

Patients had regular one-to-one time with staff throughout the day. Staff worked closely with patients to respond to their needs and help them to engage in activities. Staff were also able to facilitate leave from the ward whenever this was granted by the patient's responsible clinician.

Medical staff

There was adequate medical cover, day and night, and a doctor could attend the ward quickly in an emergency. Each ward employed a ward doctor and consultant psychiatrist. Doctors worked on a rota to provide cover out-of-hours. This meant that doctors could attend the ward promptly at any time.

Mandatory training

Staff had received and were up to date with appropriate mandatory training. The hospital required permanent staff to complete up to 21 e-learning courses. In August 2019, overall compliance with this requirement was 91%. The hospital required all permanent staff working directly with patients to complete a four-day training course on the prevention and management of violence and aggression. In September 2019, 88% of staff required to complete this training had done so. Eighty-eight percent of staff had completed breakaway training. Ninety-two percent had completed training in immediate life support. Ninety-four percent had completed training in basic life support. Agency staff complete mandatory provided by agency.

Assessing and managing risk to patients and staff

Assessment of patient risk

During the inspection, we reviewed the care records of five patients. All these records demonstrated good practice in relation to assessing individual patient risk.

When hospitals referred patients to Huntercombe Hospital Roehampton, they provided a risk assessment of the patient. This included details of the level of observation that should be provided to the patient when they arrived.

Staff completed a risk assessment of every patient on admission and updated it regularly, including after any incident. The notes showed that a doctor saw every patient when they were admitted and completed an assessment of their physical and mental health. Staff responded promptly to any concern identified in these assessments. For example, on one occasion, staff immediately took a patient to the emergency department at the local hospital for a more thorough assessment of their physical health. The multidisciplinary team reviewed each patient's risks throughout their admission. These teams included a consultant psychiatrist, occupational therapist, doctor, social worker and ward manager. The multidisciplinary team met at least twice each week. During these meetings they reviewed patients' mental health and discussed each of the risks identified on the patient's risk assessment. For example, during one review the multidisciplinary team reviewed the rating of the patient's risk in relation to self-harm, violence and aggression, suicide and absconding.

Staff used a standard risk assessment tool to record risk on the electronic patient record.

Management of patient risk

All staff were made aware of the risk each patient presented at the handover meeting at the start of each shift. At these meetings, the co-ordinator of the shift that was ending gave a verbal summary of each patient. These summaries typically included details of their Mental Health Act status, their observation level, their mood and their use of leave.

For some patients, the nurse in charge of handover gave advice on how to support the patient. For example, the nurse explained that staff should provide reassurance to a patient who was chaotic, delusional and verbally abusive. All staff said that handover meetings were helpful.

The service primarily managed risks through enhanced observations of higher risk patients. The level of observation was set by the MDT. Staff said enhanced observations meant they could closely monitor patients' moods and anticipate any potential increase in risk. If staff noticed that a patient was becoming agitated they would

use distraction techniques to help the patient move their focus away from what was causing the agitation. For example, staff encouraged patients to play a game, do a structured activity or use relaxation techniques. Staff understood how patients preferred staff to engage when carrying out observation. For example, one patient did not like staff simply watching them or sitting next to them. They preferred staff who talked to them and engaged in activities with them. We saw that staff responded to these preferences.

Staff usually applied blanket restrictions on patients' freedom only when justified. The service prohibited patients from having any items on the ward that could cause harm. However, the service worked flexibly in response to patient's needs and risk in relation to patients' access to their mobile phones.

Staff adhered to best practice in implementing a smoke-free policy. The service had introduced a smoke-free policy during 2019. The hospital provided nicotine replacement therapies, such as nicotine patches or nicotine sprays, to patients who needed them.

Use of restrictive interventions

Restrictive interventions were used regularly in the hospital. In the first six months of 2019, there were 387 incidents of restraint and 174 incidents of rapid tranquilisation, which were spread over the whole patient group. The hospital did not have a restrictive interventions reduction programme, which had been recommended during our previous inspection in January 2019. The hospital was not benchmarking its use of restrictive interventions with similar services and was not systematically reviewing the trajectory of these interventions, including identifying where peaks or troughs in the use of restrictive interventions occurred and the reasons underpinning this.

In the seven months from January to July 2019, there were 25 episodes of seclusion. There had been 13 uses of seclusion on Upper Richmond Ward and 12 uses of seclusion on Kingston Ward.

There were 387 episodes of restraint during this same period. There had been 198 episodes of restraint on Upper Richmond Ward and 142 episodes of restraint on Kingston Ward. Between March and July 2019 there had been 47 incidents of restraint on Lower Richmond Ward. This ward was closed at the time of the inspection.. Restraints were not focused on a small number of patients. Between January and October 2019, staff had restrained between 13 and 23 patients each month. This meant that in a typical month, over a third of patients were involved in at least one incident that led to them being restrained by staff.

There were 24 incidents of prone restraints. There had been 17 uses of prone restraint on Upper Richmond Ward and five uses of prone restraint on Kingston Ward. Staff in Lower Richmond Ward had used restraint twice. Prone restraint was used to manage severe aggression, administering medication and to aid a safe exit from seclusion. The hospital had introduced a procedure for administering intramuscular medication in a standing position, but this was not always safe or practical to use as an alternative to prone restraint.

There were 174 incidents involving rapid tranquilisation. There had been 96 uses of rapid tranquilisation on Upper Richmond Ward and 52 uses of rapid tranquilisation on Kingston Ward. Staff in Lower Richmond Ward had used rapid tranquilisation on 26 occasions.

During the inspection, one patient had been placed in long-term segregation. This patient was being nursed by three members of staff. The patient had been placed in long-term segregation six days before the inspection. The staff had prepared a care plan for the patient's segregation. Staff recorded their observations of the patient every four hours. Staff had arranged for the patient to be transferred to another hospital.

The hospital did not have a restrictive interventions reduction programme. The hospital director said the service was planning to introduce a conflict resolution model, 'Safewards', in early 2020. The hospital was planning to meet with a local NHS trust to learn about how to implement this programme.

We reviewed the records of five incidents involving prone restraint that had occurred in October 2019. All these records stated that staff had tried to de-escalate the situation before using restraint. For example, staff had encouraged the patient to move to the de-escalation area and offered the patient medicines to help them calm down.

Staff did not always use the correct technique for restraining patients. Records of restraint included details of the holds used, the names of the staff involved and how long the restraint lasted for. However, the local authority had recently reviewed three incidents at the hospital that

had involved inappropriate use of restraint. Two incidents involved staff pulling a patient by the arm. One of these incidents raised additional concerns about a staff member adopting a threatening stance towards the patient. One incident involved a member of staff pulling a patient's hair. During our inspection, two patients said they had been restrained in a painful manner. The hospital manager acknowledged that the current arrangements for staff to complete refresher training in restraint were not effective. The hospital was planning to change to a new model of restraint training and practice in January 2020.

Staff followed National Institute of Health and Care Excellence guidance when using rapid tranquilisation. Records showed that staff offered to carry out physical observations of patients after rapid tranquilisation. If patients refused this, staff continued to observe the patient on enhanced observations.

Staff kept records for seclusion in an appropriate manner. Records showed that a nurse reviewed patients in seclusion every two hours. A doctor reviewed patients every four hours.

Safeguarding

Permanent staff received training on safeguarding. Managers reviewed safeguarding referrals at clinical governance meetings. At the clinical governance meeting in August 2019, managers reviewed the 18 safeguarding referrals that staff had made in July 2019. On both Kingston and Upper Richmond Wards, safeguarding incidents tended to involve patients assaulting other patients.

The service did not always take sufficient steps to protect patients from abuse. Three of the eight patients we spoke with said they had been assaulted whilst at the hospital. One patient said they had been attacked by other patients. One patient said they had been slapped by another patient. Another patient said they had been punched in the face by another patient. Some patients found the ward environment to be very unsettling. One patient said they found the ward to be noisy and scary. Records of community meetings also showed that patients had reported being concerned about fighting on the wards and that some patients were fearful of other patients. During a community meeting on Kingston Ward in October 2019, one patient said there was too much noise, violence and racism on the ward.

The hospital worked in partnership with other agencies. During October 2019, the local authority held three safeguarding adults planning meetings. Each of the incidents involved allegations of staff assaulting patients during restraint or carrying out inappropriate restraint. The notes of these meetings show that the service responded by suspending staff under investigation, providing additional training for staff where appropriate and following the disciplinary process with staff who had not followed the appropriate restraint procedure.

Staff access to essential information

Staff recorded Information on the electronic patient record. Most information needed to deliver patient care was available to staff when they needed it and was in an accessible form. However, agency staff could not access electronic care and treatment records for patients or electronic incident report systems. This placed permanent staff under additional pressure to access and update electronic records on behalf of agency staff. It also meant that agency may not always have access to essential information about patients' risks and safety.

Entries on patients' progress notes were brief. Staff focused on recording the patient's mood, sleep, nutrition and physical health. There were records of patients' engagement in occupation therapy, such as details of groups that the patient had attended.

Staff also kept paper records for each patient. These included records of physical health checks. Paper records were kept in folders in the nurses' office.

Some staff commented that it was difficult to absorb so much information so quickly at the shift handover meeting. There was no written information shared in the meeting, such as paper notes or information displayed on a screen, to help staff absorb the information. One member of staff said they read through the handover book if there was anything they were unsure of, but not all staff did this.

Medicines management

Staff followed good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication) and did it in line with national guidance. The service engaged a specialist pharmacy service to provide their management of medicines.

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

Requires improvement

Staff reviewed the effects of medication on patients' physical health regularly and in line with guidance produced by the National Institute of Health and Care Excellence (NICE). Doctors discussed side effects of medication in the ward round. Staff also discussed any side-effects with patients when they dispensed the medicines.

Track record on safety

During the 12 months prior to the inspection, there had been one unexpected death. The cause of death appeared unrelated to their care and treatment. The hospital was awaiting a coroner's inquest to confirm the cause of death.

Reporting incidents and learning from when things go wrong

The quality of incident reports was variable as on occasion these were completed by staff who had not been involved in the incident as agency staff did not have access to incident reporting systems. We were told of one incident that had not been reported. On Upper Richmond Ward staff were not meeting regularly to share learning from incidents. Some learning recommendations from incidents had not been implemented and the reasons for this were not clear.

Whilst most staff said they usually reported all incidents that they should report, we were told of one occasion when an incident report had not been completed. A member of staff told us they had found a patient being observed by one support worker when they were assigned to two-to-one observations. This incident was not reported. Agency staff did not have access to electronic incident reporting system. This meant that permanent staff who had not been involved in an incident were completing the report form, which had led to variations in the quality of incident reports.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. For example, following the death of a patient, staff contacted the patient's family straight away. Staff provided the family with support and information about the circumstances surrounding the death.

Staff did not consistently meet to discuss feedback. On Kingston Ward, staff held a team meeting each month. Staff had discussed a number of incidents including safeguarding matters, incidents of self-harm and specific risks relating to individual patients. There had been no team meetings on Upper Richmond Ward in almost five months prior to the inspection. This meant that staff had not had the opportunity to discuss incidents and share any learning from incidents with other colleagues working on the ward.

There was no evidence that changes had been made as a result of feedback. For example, the report of an investigation into an incident in March 2019 recommended that staff receive training in the management of anaphylaxis and to practice medical emergency drills covering a variety of scenarios including anaphylaxis. This work was due to be completed by the end of October 2019. None of the staff we spoke with said that they had received this training or participated in emergency drills.

Staff were debriefed and received support after a serious incident. Staff explained that people involved in an incident usually met for an incident de-briefing. However, meetings were not recorded. This meant the discussions could not be shared with colleagues. Each ward also held reflective practice sessions.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Requires improvement

Leadership

During recent years, managers had not had the right skills and abilities to run a service providing high-quality sustainable care. At all the CQC's previous inspections since 2015, inspectors had rated the service as either requires improvement or inadequate. During this period the CQC had issued three requirement notices relating breaches of the Health and Social Care Act regulation concerning the governance of the hospital. At this inspection, we found that the hospital manager had moved on from their role shortly before the inspection. An interim hospital manager had been in post for four weeks. The manager had 10 years' experience of working in low secure settings. Their previous role was the senior quality assurance manager within the central Quality and Assurance Team for The Huntercombe

Group . In this role, they supported hospitals to improve the quality of their services. Ward managers were registered nurses. The ward manager on Upper Richmond Ward had been in their role for over two years.

The manager had a clear understanding of the challenges facing the hospital. In their first four weeks, they had set their priorities as addressing the staffing vacancies and reducing restrictive practices. Senior staff on the wards, such as ward managers and consultant psychiatrists, met with patients at ward rounds. They knew their patients well. They had a good understanding of each patient's condition, needs and circumstances.

Staff said they knew the hospital manager, the ward manager and shift co-ordinators.

Some leadership development opportunities were available, including opportunities for staff below team manager level. For example, the hospital manager had invited members of staff to apply for roles in leading the new approach to restrictive practice that the service was planning to introduce in January 2020.

Vision and strategy

Permanent staff knew and understood the provider's vision and values and how they were applied in the work of their team. The service displayed a statement of its values on its website. The values included understanding patients' needs, putting patients first, being innovative, accessible and reliable, and striving for excellence. Many staff discussed these values with us during interviews. For example, some staff spoke positively about getting to know patients by talking with them every day and how this helped them to have a better understanding of patients' needs. Staff gave examples of how they had responded to patients' needs such as helping a patient to call their family when they felt homesick and providing personal care to patients experiencing self-neglect.

Agency staff were not aware of the provider's vision and values. The responsibility for modelling the provider's vision and values fell to a small number of permanent unregistered nurses.

Staff on Upper Richmond Ward did not have the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. On this ward, the ward manager had not held a team meeting for almost five months. During this time there had been a number of changes, including there being a new hospital manager. On Kingston Ward, there was usually a team meeting each month. During these meetings staff discussed some matters relating to change within the hospital such as the change of hospital manager, the action log for items on the risk register and a review of prescribing medicines on an 'as required' basis.

Culture

We identified some potential risks as to how the provider ensured that the culture on the wards at all times reflected their vision and values, particularly at night. There was more for the provider to do to ensure these potential risks were managed or mitigated. A number of whistleblowers had raised concerns with us prior to the inspection regarding safety, leadership and cultural issues. The majority of incidents at the hospital related to patient on patient violence. The majority of staff providing direct patient care during night visits were agency staff. This had been the case for many months. This resulted in a risk that inconsistent care could mean that staff did not know the particular wishes, likes and dislikes of the patients they were assigned to work with, or how to respond in the way that best met their needs and preferences to de-escalate a situation.

The low ratio of registered nurses to non-registered nurses on duty on Upper Richmond Ward on the night of our visit meant that the nurse in charge had to spend a large proportion of their time dealing with management tasks. This meant there was no visible presence of registered nurses on the ward for staff and patients to engage with. It also meant that the managers capacity to know what was happening on the ward was limited. A high proportion of the staff group providing direct patient care were non-registered agency staff who potentially had little connection to other professionals working in the hospital. Agency staff did not receive supervision and did not attend team meetings.

We saw that at night, permanent, non-registered nurses were setting the culture for the ward, with little support and training to do this. Whilst we saw that non-registered nurses were working hard to model the provider's vision and values, safeguarding investigations concluded in October 2019 indicated that a small clique of staff working in the hospital at night may have developed their own

unhealthy culture which may have contributed to three incidents where inappropriate restraint holds were used. The provider had taken appropriate disciplinary action in response to the safeguarding investigation's findings.

The hospital is geographically isolated from other hospitals operated by the provider. This was the only psychiatric intensive care unit for adults operated by the provider, which means there was a risk that the hospital is organisationally isolated. This meant there were no other hospitals nearby with whom the service could share good practice and work collaboratively to address challenges.

However, during our inspection we saw that staff used respectful language when they spoke about and spoke to patients. We also observed that staff sought to understand the reasons for particular behaviours and did not prioritise routine tasks over spending time with patients. There were independent advocacy services. The hospital was developing links with a local NHS trust to consider how it could introduce a 'Safewards' approach in the hospital. During an engagement meeting with CQC in September 2019, the hospital manager acknowledged that there was more work to do to ensure that the hospital culture mirrored the provider's vision and values at all times.

Staff acknowledged that there had been some improvement in morale since a new hospital manager had begun in post at the beginning of October 2019. During reflective practice sessions in July 2019, staff morale was clearly very low. Staff said they felt excluded from teams, unsupported and unsafe. Staff said that communication was poor and vital information was getting lost.

During the inspection, staff said they felt respected and valued. All the staff we interviewed spoke positively about the service and many said they were proud to work at the hospital. Some staff said that staff worked together as a family. Permanent staff said they were supported during monthly supervision.

During the inspection, staff told us they felt able to raise concerns without fear of retribution. Staff said that if they had any concerns they would speak to their colleagues, the shift co-ordinator, the ward manager or the hospital manager. However, none of the staff talked about a specific whistleblowing procedure. We did not see any information about whistleblowing displayed in nurses' offices. One non-registered nurse said they had raised concerns in the past but felt that managers had not listened to them. Prior to the inspection several whistle blowing concerns regarding safety and leadership had been raised with us, with the complainants stating that the concerns they raised had not been listened to.

Managers dealt with poor performance of permanent staff when needed. Ward managers held supervision sessions with permanent staff each month to monitor their performance. When allegations were made, the hospital acted promptly to suspend the member of staff whilst the matter was investigated. If investigations found that a member of staff had acted inappropriately, the manager issued warnings to the member of staff in accordance with the disciplinary process. As part of the disciplinary process, staff were required to repeat relevant training.

Staff said they found their colleagues supportive.

The provider recognised staff success within the service. Huntercombe Hospitals held its first annual awards ceremony to recognise staff success in September 2019. The organisation awarded staff for outstanding achievements in relation to its values. For example, there were awards for reliability, working towards excellence and putting people first.

Governance

Systems and procedures did not operate well to ensure the safe, effective running of the hospital. The service was effective in recruiting and retaining suitable staff. Since our previous inspection in January 2019, the hospital had closed one ward and redeployed these staff onto the remaining wards. Whilst this meant that there were more permanent staff to deploy on Kingston and Upper Richmond Wards, the hospital still faced significant challenges in recruiting permanent staff, which meant that agency staff were being used to cover vacant shifts. The provider's model of care relied upon flexibility in staffing numbers. Whilst some bank staff who were employed by the hospital were used, the provider relied heavily upon agency staff to meet increased staffing needs due to patient acuity.

There was no system or process to supervise agency staff or include them in team meetings to review governance information. The service relied upon ad hoc reports from permanent staff and patients to identify any concerns. This was not a robust process to ensure that all agency staff working shifts with the provider demonstrated the knowledge, skills, values and competence required to

deliver safe, effective care. We were also told of one incident that had occurred that had not been reported. There was no formal system to review the performance of agency staff.

The hospital did not have a system or process in place to consider how to effectively and safely manage beds that took patient acuity into account. For example, there was no mechanism to consider the possibility of halting new admissions or other appropriate interventions, when high numbers of existing patients required nursing on continuous 1:1 or 2:1 observation.

There was a framework of what must be discussed in team meetings. However there had been no team meetings on Upper Richmond Ward for almost five months. This meant that staff had not had the opportunity to discuss changes to the service or any incidents that had taken place.

Our previous report of the inspection in January 2019 recommended the service introduce a reducing restrictive interventions strategy. At this inspection, we found that there had been no progress in addressing this until the new hospital manager had come into their post in October 2019. Staff had not always implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. The report of an investigation into an incident in March 2019 recommended that staff receive training and carry out emergency drills. This had not taken place.

However, systems and processes were working effectively to ensure that the wards were clean and patients were appropriately assessed. Clinical governance meetings, covering patient safety, the quality assurance framework, lessons learned from incidents and safeguarding. On Kingston Ward, team meetings usually took place once a month. Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. The results of audits of hand hygiene, care plans and risk assessments, physical health and the management of medicines were reviewed at the Clinical Governance meeting in August 2019.

Management of risk, issues and performance

Managers maintained a risk register for the hospital. The risk register for the hospital included details of the risk, a risk rating on a scale of one to 10, an action plan explaining how the risk was being addressed and a deadline for the completion of these actions. The service displayed a simplified version of the risk register in the nurses' offices covering the six highest risks.

Only some staff concerns matched those on the risk register. Staff spoke to us about risks relating to low numbers of permanent staff and patients' frustrations about the no smoking policy that had been introduced in March 2019. Both these matters were on the register. However, the risk register did not cover the risks relating to assaults on staff and patients or the use of restrictive practices on the wards.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Only the permanent 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. Agency staff were unable to access some electronic records systems, including electronic patient records and incident reporting, which placed an undue burden on permanent staff and impacted upon the quality of records.

Information governance systems included confidentiality of patient records. Staff required a personal password to access the electronic patient record. Paper records were stored in locked filing cabinets in the nurses' office.

Staff made notifications to external bodies as needed. For example, the service made statutory notifications to the Care Quality Commission in accordance with the Health and Social Care Act Regulations 2009.

Engagement

Patients had some opportunities to give feedback on the service they received. Each ward held a community meeting each month. However, the average length of stay on the wards was between two and three weeks. This meant that some patients would be admitted and discharged without the opportunity to attend a community meeting. The ability of patients to give feedback varied.

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

Requires improvement

Some patients were clearly able to express their views and opinions. However, many patients found it difficult to communicate due to being overwhelmed by their anxieties or due to the severity of their mental health symptoms.

Managers and staff had access to the feedback from patients and carers. Managers reviewed complaints from patients and their carers in clinical governance meetings. For example, in August 2019 managers reviewed 11 complaints. Records do not show any specific learning or changes to the service in response to these complaints.

Learning, continuous improvement and innovation

The service was at the early stages of considering improvements and innovation. For example, the service had plans to introduce a restrictive intervention reduction programme in January 2020. However, the service had made very little progress since the last inspection in January 2019.

The hospital had not participated in accreditation schemes relevant to the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on each shift to ensure that patients receive consistent, safe, care from staff who are familiar with the hospital and other members of the team and who understand how to meet the complex needs of patients using a psychiatric intensive care service. The provider must review the model of care to move away from a reliance on using high numbers of agency staff. **Regulation 18(1)(2)(a)**
- The provider must ensure that patients receive care in a therapeutic environment that supports their recovery and ensures their safety and well being. The service must offer an improved quality of relational security and move away from a reliance on high levels of enhanced observations. **Regulation 9(1)(a)(b)(c)**
- The provider must ensure that lessons learnt from incidents and safeguarding concerns are shared with all relevant staff. The provider must also ensure that identified actions from incident investigations are implemented in a timely fashion. **Regulation 17(1)(2)(a)(b)(f)**
- The provider must ensure that all appropriate means to reduce the use of restrictive interventions are implemented without further delay. **Regulation 17(1)(2)(a)(b)(f)**
- The provider must ensure that all staff always use the approved techniques that they have been trained in should patients require restraint. **Regulation 12 (1)(2)(a)(b)(c)**
- The provider must ensure that all staff have appropriate access to electronic records systems, including patient care and treatment records and incident reporting systems. **Regulation 17(1)(2)(a)(b)(f)**
- The provider must ensure that governance systems and procedures ensure the safe, effective running of the hospital. For example there should be a robust system to obtain feedback on the performance of agency staff; Staff should have access to regular team meetings to discuss quality and safety issues relating to the operation of the service. **Regulation 17(1)(2)(a)(b)(f)**
- The provider must ensure that appropriate measures are put in place to ensure that the culture on the wards reflects the organisations vision and values. **Regulation 17(1)(2)(a)(b)(f)**

Action the provider SHOULD take to improve

- The provider should ensure that handover meetings are arranged in a way that helps staff to absorb the large amount of information that it presented.

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
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury