Calverton Hill

Quality Report

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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 effective?	Requires improvement
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

We did not rate Calverton Hill at this inspection. We rated Calverton Hill as requires improvement overall following our previous inspection in October 2019 and the acute mental health wards as inadequate for safe and requires improvement for effective, caring, responsive and well led.

Whilst there was evidence of improvements it was too soon to evaluate the impact as the changes were not embedded. The warning notice was not fully met because:

- Staff were still not always clear about what items were restricted for each patient and why. Records showed that staff did not always assess risks to patients and themselves well.
- Blanket restrictions remained in place, for example, patients on Bestwood Ward were not able to make hot drinks. Staff searched all patients and their property on admission without evidence of individual risk assessment for this in line with the search policy. Staff were not always confident about how to document searches.
- Some staff still did not know about environmental risk assessments.
- There was no robust system in place to ensure staff completed cleaning records to show when cleaning tasks were completed.
- However:
- The wards including the clinic rooms were clean, which had improved from our previous inspection.
- There were sufficient quantities of medicines available to ensure the safety of patients and to meet their needs, which had improved.
- Staff carried out observations on patients in line with policy and recorded these at the time of the observation, which had improved.

We also found at this inspection:

- Nursing staff told us that they did not always have time to interact with patients and patients did not always have regular one to one sessions with their named nurse.
- The electronic records systems the hospital used did not provide easy access to clinical information and did not make it easy for staff to maintain high quality clinical records.
- Staff did not always review the effects of rapid tranquilisation medicine on each patient's physical health consistently and did not always record the reasons for giving patients as required medicines.
- The recording of incidents varied, and some staff told us they did not receive information about lessons learned following incidents they had been involved in or reported.
- The provider had trained staff in how to work with and support patients with a personality disorder and the needs of patients admitted to acute mental health wards, however some staff did not have the skills and knowledge needed.
- Staff did not effectively use recognised rating scales to assess and record severity and outcomes of patient's physical health needs.
- Staff meetings did not take place monthly and some staff said their supervision was not monthly as expected.
- The governance systems were not robust enough to ensure that the environment was safe and clean and equipment such as patients call bells worked when needed.

  However:
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed.

Summary of findings

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

  Following this inspection, we met with the registered manager, the Priory Healthcare operations manager and regional director to discuss our ongoing concerns. We agreed to increase our engagement and monitoring of the hospital and to bring forward the next comprehensive inspection. The provider has put the hospital onto their enhanced support programme which expects turnaround within twelve weeks.

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	Requires improvement 	**We did not look at all elements of the safe domain at this inspection. At our previous inspection in October 2019 we rated safe as inadequate. We did not change the rating at this inspection because:** • Staff did not assess and manage risks to patients well. Staff did not always assess patients' individual risks well which meant they sometimes used blanket restrictions to manage patients. • Nursing staff did not always have time to interact with patients and patients did not always have one to one time with their named nurse. • Some staff were not aware of the ward environmental risk assessment. • Staff did not have easy access to clinical information, and it was not easy for them to maintain high quality clinical records. • Staff did not always review the effects of rapid tranquilisation medicine on each patient's physical health consistently and did not record the reasons for use of as required medicines. • The recording of incidents varied in that not all incidents showed what action had been taken as a result to prevent harm to the patient. Some staff told us they did not receive information about lessons learned following incidents they had been involved in or reported. • However: • The wards were clean. • The service had enough nursing and medical staff, who knew the patients. • Staff followed best practice in anticipating, de-escalating and managing challenging behaviour and only used restraint after attempts at de-escalation had failed.

Summary of findings

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- **We did not look at all elements of the effective domain at this inspection. At our previous inspection in October 2019 we rated effective as requires improvement. We did not change the rating at this inspection because:**
- Some staff did not have the skills and knowledge needed to work with and support patients with a personality disorder and the needs of patients admitted to acute mental health wards.
- Staff did not effectively use recognised rating scales to assess and record severity and outcomes of patient's physical health needs and act where needed.
- Staff meetings did not take place monthly and some staff said their supervision was not monthly as expected.
- **We did not look at all elements of the well led domain at this inspection. At our previous inspection in October 2019 we rated well led as requires improvement. We did not change the rating at this inspection because:**
- Managers had not made enough improvements to the service since our previous inspection.
- The governance systems were not robust enough to ensure that the environment was safe and clean and equipment such as patients call bells worked when needed.
- There was no evidence to show that audits improved the care and treatment of patients.

Summary of findings

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Requires improvement

Calverton Hill

Services we looked at

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

Summary of this inspection

Background to Calverton Hill

Calverton Hill hospital is provided by Priory Healthcare Limited and registered to provide assessment or medical treatment for persons detained under the Mental Health

Act, diagnostic and screening procedures and treatment of disease, disorder or injury.

The hospital offers a medium secure service for women with a learning disability on Clumber Ward. However, this ward was expected to close in February 2020. We did not inspect Clumber Ward at this inspection as the ward was due to close and the warning notice we served after our previous inspection did not relate to this ward.

There were two acute mental health wards for men and women; Newstead and Bestwood wards. There were 16 beds on each ward and the service is commissioned by Nottinghamshire Healthcare NHS Foundation Trust. There were 14 patients on each ward at the time of our inspection.

There have been 14 previous inspections to Calverton Hill hospital. The latest was in October 2019 when we rated Calverton Hill as requires improvement overall, inadequate for safe and requires improvement for effective, caring, responsive and well led. We made five requirement notices relating to Regulations 9, 11, 10, 17 and 18 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014. We also served a warning notice relating to Regulation 12. We undertook this inspection to look at progress made in relation to the warning notice and only inspected Newstead and Bestwood Wards.

Our inspection team

The team that inspected the service comprised four CQC inspectors and one nurse specialist advisor.

Why we carried out this inspection

We inspected this service to look at progress made following the warning notice served on Regulation 12 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014. This was served following concerns identified at our previous inspection in October 2019.

How we carried out this inspection

We only looked at parts of the key questions of Safe, Effective and Well led at this inspection. We did not look at all key lines of enquiry in these domains.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited Bestwood and Newstead Wards, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with five patients who were using the service;
- spoke with the registered manager, the manager for Bestwood Ward and acting manager for Newstead Ward;
- spoke with 15 other staff members; including doctors, nurses and psychologist;

Summary of this inspection

- looked at seven care and treatment records and 23 prescription charts of patients:
- carried out a specific check of the medication management on both wards; 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

Patients told us the wards were clean.

Patients told us the wards were always well staffed. They said staff explained to them about their medication and gave them leaflets about it.

Patients we spoke with said they felt safe on the wards.

Patients and carers told us that staff were kind and caring.

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**
Are services effective?	**Requires improvement**
Are services well-led?	**Requires improvement**

Detailed findings from this inspection

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	Requires improvement	N/A	N/A	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	N/A	N/A	Requires improvement	Requires improvement

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

Requires improvement

Safe	Inadequate
Effective	Requires improvement
Well-led	Requires improvement

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

Inadequate

Safe and clean environment

We observed that Bestwood and Newstead Wards were cleaner at this inspection. Patients also told us the wards were clean. Following our previous inspection in October 2019, staff had completed a deep clean of the wards.

Whilst the clinic rooms were cleaner than at our previous inspection, managers had still not put in place effective governance systems to ensure their ongoing cleanliness. For example, cleaning records did not show that staff had completed the specific tasks required to be carried out at a set frequency to keep the wards clean. Staff told us that night staff cleaned the clinic room on Bestwood Ward, however, the cleaning records could not be found. We discussed this with managers who immediately set up a system requiring domestic staff to initial when they had completed the cleaning of an area. Since our previous inspection, staff said they were allocated a specific responsibility on each shift to support patients to tidy their bedrooms. While this was an improvement since our previous inspection, audits on Newstead Ward, completed in January 2020, showed that some bedrooms were untidy and dirty and there was no clear action that staff had taken following these audits to rectify this. This was an issue with the governance systems as managers had not identified this and taken action to make the improvements needed.

Repairs to the hospital's environment were not always completed in a timely manner. For example, a repair had been reported on 8 October 2019 but was not completed until 11 December 2019. The provider told us that all maintenance requests were discussed and prioritised at the daily risk meeting and a maintenance book on each ward checked by the maintenance team daily to make the process more efficient. We saw the walls of ensuite shower rooms were worn and needed painting. However, the provider had a plan in place to refurbish the hospital wards when the medium secure ward closed.

Clinic rooms were well equipped with suitable handwashing facilities and the necessary equipment to carry out physical observations. Resuscitation equipment and emergency drugs were accessible. Although staff carried out checks on equipment, they did not check it regularly.Records showed staff checked the emergency bag on Newstead Ward twice in January 2020 and twice in February (once at the time of our inspection). We found an item used for blood glucose monitoring in the emergency bag on Newstead Ward which expired on 31 January 2020. Staff had noticed this in their audit on 1 February and recorded that it should remain in the bag until replaced. Staff said if there was an emergency, a staff member would attend from other wards with their emergency bag which would reduce the impact to patients.

Since our previous inspection, staff knowledge of ward environmental and ligature risk assessments had improved, however, the ward manager on Bestwood Ward told us they had not seen the risk assessments. We looked at the ward risk assessments and saw these were completed in March 2019 for all areas of the hospital except the bathrooms. This was because patients did not have access to the bathrooms on either ward as they had an ensuite shower room in their bedroom.

The provider had installed anti-ligature fixtures and fittings where possible, and there were ligature cutters on both wards that were easily accessible to all staff. Staff had identified ligature anchor points which were detailed on the ligature audits for each ward. The ward layout allowed staff to observe most areas of the ward. The provider had installed closed circuit television cameras and mirrors to reduce blind spots in communal areas and reduce risks. Staff observations and presence in communal areas further

reduced the risks to patients. Staff followed the providers' policy in observing patients which was an improvement from our previous inspection. Staff staggered the times when they did this to minimise risks to patients. However, some staff were not aware of ways to reduce risks of ligatures from ensuite doors in patients' bedrooms, such as observing patients within each hour.

Access to both wards was controlled and doors were locked. There were books for visitors to sign in and out to ensure that staff knew the number of people on each ward.

Staff had easy access to personal alarms and radios and patients had access to a nurse call system via a button in their bedrooms. However, managers had not put in place governance systems for staff to regularly check the alarms to see if they would work when needed. One patient told us their call button had not worked when needed but was repaired soon after, fortunately the patient had been able to go out of their bedroom to alert staff instead.

The wards complied with guidance on eliminating mixed-sex accommodation. Both acute wards met the CQC's guidance and the Mental Health Act code of practice, male and female sleeping areas were segregated with access to their own toilet facilities. The wards also had male and female only lounges.

Safe staffing

The service did not have enough nursing and support staff with the skills and experience needed to keep patients safe. Since our previous inspection, the provider had employed more staff, the staff vacancy levels had reduced and there were the numbers of staff needed on each ward. Staff and patients reported improved staffing levels. However, nursing staff told us that they still did not always have time to interact with patients and patients did not always have regular one to one session with their named nurse.

At the time of our inspection on Bestwood Ward, there were two registered nurses and six healthcare workers on each day shift and two registered nurses and seven healthcare workers on each night shift. On Newstead Ward there were two registered nurses and four healthcare workers on each day shift and two registered nurses and three healthcare workers on each night shift. There were five registered nurse vacancies on Newstead Ward and 4.15 whole time equivalent on Bestwood Ward. The provider was in the process of recruiting to these posts and offers had been made to reduce these further. Some staff had been moved from the medium secure learning disability wards which had closed or were closing. This had helped to reduce vacancy levels however these staff did not have experience of working on an acute mental health ward so may not have the skills needed. The provider told us as at January 2020, 89% of staff had completed their mandatory training.

The ward managers could adjust staffing levels according to the needs of the patients. Additionally, there was a site coordinator for each shift who was responsible for covering shifts that were short staffed. They reviewed the staff numbers and skill mix on each ward and moved staff across wards to ensure there were safe staffing levels across the hospital site. Managers limited their use of bank and agency staff and requested staff familiar with the service. There were two agency locum registered nurses on Newstead Ward and one on Bestwood Ward. These staff were employed on a long-term basis and knew the wards and the patients well. There were no healthcare worker vacancies. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. When necessary, managers deployed bank nursing staff who were familiar with the wards to maintain safe staffing levels.

Staff turnover rates had reduced since our previous inspection. The registered manager reported that for the last 12 months these were 1.2% on Newstead Ward and 2.7% on Bestwood Ward. However, staff told us that staff retention was not good and several staff had left including the ward managers which they felt impacted on the service. The sickness rate on both wards was higher than in the 12 months before our previous inspection which was at 2.3%. The sickness rate was 5.2% in October 2019, 3.8% in November 2019 and 5.4% in December 2019. The registered manager told us they had seven staff members on long term sick which has skewed the recent figures, as well as organisation wide increase in sickness for the last three months of 2019. They said staff on long term sick are supported through a robust return to work supportive process.

We observed that a registered nurse was always present in communal areas of the ward which was an improvement from our previous inspection. The ward managers had changed on both wards since our previous inspection. The ward manager on Bestwood Ward had moved from Clumber Ward which was a medium secure learning

disability ward and did not have previous experience of working on an acute mental health ward. While the newly appointed clinical lead nurse on Newstead Ward told us, they were recruiting to their ward manager post.

The provider employed enough doctors. The service had enough daytime and night time medical cover and a doctor available to go to the wards quickly in an emergency. There was a doctor on site at night.

Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. Informal patients were able to leave the ward at free will and detained patients were individually risk assessed for leave. Ward activities were led by the occupational therapy and wellbeing teams, so any nurse staffing shortages did not affect the activities that patients could take part in.

The service had enough staff on each shift to carry out any physical interventions safely. There was an alarm system in place for staff to call from the wards across the site to help support during physical interventions. There were de-escalation rooms on both wards that were equipped with bean bag type furniture which allowed patients to be restrained safely. Staff felt supported when needed to carry out physical interventions safely.

Assessing and managing risk to patients and staff

As at our previous inspection staff did not always assess and manage risks to patients well. We looked at seven care records of patients and still had concerns at this inspection. Staff completed a risk assessment for each patient on admission, using a recognised tool. Four records showed that staff reviewed risk assessments weekly at the patient's ward round and after every incident. However, three patients' risk assessments lacked detail about the patients' documented risks and how staff were to manage this to reduce risks to the patient. The records for one patient, who was admitted the week before our inspection, did not include a full assessment of their risks. Three patients' records did not show that risk assessments were always reviewed weekly. One patient's risk assessment was not updated following an incident where the patient self-harmed and another was not updated following an incident where the patient needed to be restrained.

As at our previous inspection staff did not always act to prevent or reduce risks to patients. Staff were not always clear about what items were restricted for each patient and why. There was a clear list of restricted items on each ward and each patient had a lockable cupboard to keep these in. Staff said restricted items were signed in and out and there was an allocated staff member on each shift to do this. On Bestwood Ward we saw three omissions of staff signing these items back in, so it was not clear whether the patient had these items or not. In three patients records on Newstead Ward we saw staff had restricted the patients use of items that were not on the restricted items list. However, there was no rationale in their risk assessment for this.

Staff searched all patients and their property on admission and when returning from leave which was in line with Calverton Hill searching patients and their belongings policy. However, the policy also states that this is subject to individual risk assessment. Staff told us they had completed random room searches for a patient, but we did not see this documented in the patient's risk management plan. Some staff told us they did not know how to document searches.

On Bestwood Ward there was a blanket restriction in place that meant patients could not make themselves hot drinks. This was due to the risk of one patient. However, throughout our inspection we observed staff offered patients hot drinks to reduce the impact of this.

Staff understanding and implementing of the providers smoking policy had improved since our previous inspection but still some staff were unclear about this. Patients were able to smoke in a designated area of the site and could smoke e-burners on the ward. However, during the inspection we observed patients smoking by the main reception area of the hospital. On Newstead Ward managers had completed a health and safety audit in January 2020. This showed that some patients had been smoking cigarettes in their bedrooms, which is a potential fire risk. However, it was not clear what action managers had taken to reduce this.

Informal patients on both wards could leave at will, and there was signage on each ward to tell patients this.

There were no seclusion facilities for either acute ward. The provider trained staff in physical interventions, breakaway and restraint techniques and ensured that all bank and locum agency staff were trained in these. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when it was necessary to keep the patient or others safe.

Staff did not always follow National Institute for Health and Care Excellence guidance when using rapid tranquilisation and staff were not always clear of what rapid tranquilisation was. (The National Institute for Health and Care Excellence defines rapid tranquilisation as medicines given as an injection (not orally) to reduce the risk of harm and minimise agitation and violence.) We reviewed patients' prescription charts and medicines records and found that one patient's records stated staff had given the patient rapid tranquilisation four times in January 2020, but staff had not monitored the effects of this on the patient. Audits had not identified this. We discussed this with the registered manager following this inspection. On investigation they found that registered nurses had made errors in recording what medicine they had given to the patient. The patient had only been given rapid tranquilisation once where they had refused observations and the staff had stayed with the patient. However, staff had not recorded this. In response to this being identified, the registered manager invited all nurses involved to a team incident review meeting.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The provider trained staff on how to recognise and report abuse, and staff knew how to apply it.The provider trained staff in safeguarding adults and children and staff knew how to raise a safeguarding concern and did so when appropriate. Staff knew how to identify adults and children at risk of or suffering significant harm and gave examples of indicators and the types of incidents that they would report to safeguarding.

There were safe procedures for children visiting the service and staff followed them. There was a visiting room suitable for children located near the main reception area which was equipped with toys and games for children. This was risk assessed for each patient, and staff promoted visits with children whilst patients were on leave.

Staff access to essential information

Staff had access to clinical information, but it was difficult for staff to clearly find all the information needed for each patient. The service used a combination of an electronic record system, the network shared drive and paper records. This issue was found at the previous inspection. Staff told us this was to be replaced by one electronic system at the end of January 2020 but was not in place at the time of our inspection. Following this inspection, the registered manager told us the new system would be in place within the next three months. They also said some staff had been assigned as ambassadors for the new system to fully engage all ward staff when the system is released.

Records were stored securely.

Medicines management

Since our previous inspection, the systems for safely prescribing, ordering, and storing medicines had improved. At our previous inspection there were not always medicines available to patients when they needed them. There was now a central clinic in the hospital, and this had improved stock availability. Staff said if medicines were not available, they could order them, and they were received by the next day or they could request them from a local pharmacy in an emergency.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff followed current national practice to check patients had the correct medicines.

The systems for administering and recording medicines still needed to improve. One patient's medicine record on Newstead Ward recorded they had been given PRN (as required) medication on 24 consecutive nights before our inspection. However, this had not been discussed in their ward round and there was no rationale recorded as to why it was given. This was not in line with the Priory Healthcare 'medicines management in hospitals' policy which stated, 'Nurses must use clinical judgement when administering PRN medication and document their rationale when making the decision'.

On Bestwood Ward, we found that a medicine was not available, but it was on the checklist as needed. The director of nursing investigated this following the inspection and found this had been ordered and received on the day of inspection. Managers reviewed the ordering process and the checklist form to ensure that medical equipment and medicines nearing expiration were identified in a timely manner.

The pharmacy who supplied medicines to the hospital completed a weekly audit and sent their report to managers. The clinical lead on Newstead Ward told us if any discrepancies noted they would ask the nurse

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

Requires improvement

responsible to respond to this and then monitor progress. We looked at the audit for 28 January 2020 where nurses had not always recorded that they had given medicines as prescribed. However, it was not clear what action had been taking following this.

Track record on safety

Since our previous inspection in October 2019, the provider had reported 18 incidents to us as required. These included incidents of patients self-harming behaviour, medicines errors, patients behaving in a disruptive or aggressive way and absence without authorised leave.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. However, the recording of incidents varied. We looked at seven incident records, staff had only recorded the outcome for two of these. Staff had not detailed the outcome of a further two incidents and two were still under investigation by the director of nursing. Staff recorded another incident as no harm or impact to the patient. However, we were informed of this incident of self-harm and the patient had to attend the local accident and emergency department for treatment.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. We saw an incident where there had been a medicines error by staff. Staff had explained this and apologised to the patient and their carer.

Managers debriefed and supported staff after any serious incident. Staff told us that incidents were discussed in morning meetings, lessons learned were discussed in ward clinical governance meetings and information from this discussed with staff. Managers also told staff about this through emails, supervisions and through the safety bulletins available to all staff on the wards. However, two staff told us they did not receive feedback from investigation of incidents.

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

(for example, treatment is effective)

Requires improvement

Best practice in treatment and care

Since our previous inspection, the provider had employed a registered general nurse and healthcare worker trained in physical health. However, we have not seen much improvement in staff monitoring of patients' physical health needs. Five records we looked at showed that staff did not effectively monitor patient's physical health needs. Staff used the NEWS2 tool to monitor patients' physical health needs. However, in one patients records staff had not completed the patient's respirations for 10 of 25 days. This meant that the tool would not be effective in monitoring if the patients physical health needed treating. Another patient's record did not record that staff acted when the tool indicated this was needed. Following our inspection, the registered manager told us they were now using the LESTER tool (prompt for clinical staff conducting patient's physical health checks) along with the NEWS2 score and the multidisciplinary team reviewed these with the patient in their ward round. They told us that all staff would receive a presentation on this within four weeks of our inspection and this would be delivered on induction training from March 2020.

Skilled staff to deliver care

Whilst the provider had provided personality disorder training for all staff, we found at this inspection that this training had not improved the skills and knowledge of all staff. Staff told us they lacked the skills needed to support patients and meet their needs. The registered manager told us that managers were working with staff through monthly reflective practice sessions and supervision to increase skills and knowledge.

Staff told us that staff meetings did not take place monthly and some staff said their supervision was not monthly as they had expected it when employed. They felt this impacted on patient care and on their skills and knowledge.

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

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

Requires improvement

Requires improvement

Governance

Our findings at this inspection demonstrated that governance processes did not operate effectively at ward level and performance and risk was not managed well. There were not effective systems to check equipment, such as patient call bells, and robust systems to ensure cleaning and repairs were completed.

Managers had not identified in audits that staff recording of medicines they had given to patients was not in line with the providers policy and that staff were not aware when they were giving rapid tranquilisation to patients. Managers had also not identified that staff had not recorded outcomes of audits and the actions taken, so it was not clear if improvements had been made. Following this inspection, the registered manager told us that they had developed a master audit matrix to monitor what audits needed to be completed and who was responsible for monitoring action plans from these.

Some of the issues raised following our previous inspection had not improved, for example, staff understanding of restricted items and assessment of risk and managers had not fully addressed these. Following this inspection, senior managers within the organisation acknowledged the management issues and have put the service onto their enhanced support programme to address this.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

We issued three requirement notices to the provider. This meant the provider had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of three legal requirements at Calverton Hill.

The provider must ensure that patients' physical health is routinely monitored and recorded, including after giving rapid tranquilisation.

Staff must act where needed to ensure the patients physical health needs are met.

The provider must ensure that patients' risk assessments are detailed to include all patients risks and reviewed regularly and after incidents.

The provider must ensure that there is a robust system in place for monitoring the use of restricted items and should ensure they meet the Mental Health Act code of practice in the management and review of restricted items.

The provider must ensure that there are not blanket rules in place, for example, searching of patients or access to hot drinks.

The provider must ensure that cleaning records are completed in full and are up to date, and that all tasks are completed to the set frequency.

The provider must ensure that where multiple systems are used to record patient information, that this is effective and all necessary information such as risks are recorded.

The provider must ensure that audits contribute to making improvements where needed and actions taken are clearly recorded.

Action the provider SHOULD take to improve

The provider should ensure that training staff in working with patients who have a personality disorder and meeting the needs of patients on acute mental health wards is effective and used in staff practice.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: There was not a robust system in place for monitoring the use of restricted items. There were blanket rules in place for searching patients. Some staff were not aware of the environmental risk assessments. Cleaning records were not completed, and tasks were not completed according to the set frequency. Risk assessments were not detailed to include all patients risks and reviewed regularly and after incidents. This was a breach of Regulation 12.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Staff had not assessed and recorded all patient's physical health observations correctly and acted where needed to ensure their physical health needs are met. This was a breach of Regulation 9.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:

The provider was storing patient information in multiple places. This made it difficult to clearly identify where information was and to triangulate and information was not up to date across all systems.

The governance at ward level was not robust. Actions from audits were not completed. Managers were not acting on issues to resolve them. Clinical audits did not contribute to improving the service.

This was a breach of Regulation 17.