Priory Hospital Blandford

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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

This inspection was a focussed inspection so therefore did not provide a rating. The purpose of the inspection was to see if the provider had made significant improvements to the service following the issue of a section 29 warning notice in May 2019.

- Staff, with the support of managers, had improved their assessment and management of patient risk. They reported that the service had become more settled since the previous inspection. Positive behavioural support plans were being used more effectively. The number of incidents of restraint had reduced. Assaults on staff had reduced, and staff felt better supported. Young people and staff reported that they felt safer on the wards.
- The provider had updated their process for under-taking the initial assessment of young people being considered for an admission. This was to ensure that they were able to meet the individual needs of the young people. This amended assessment had not yet been implemented but had been approved by commissioners.
- Staff had worked hard to improve young people's care planning. Care plan documentation was more

Summary of findings

comprehensive. They included risk management plans. The care plans were more recovery focussed, highlighting the goals and the interventions needed to achieve them.

However:

- At the previous inspection there had been incidents where young people had been able to lift the bricks out of the patio which could be used to harm staff, other young people or themselves. At this inspection these bricks were still easy to lift out and were associated with ongoing incidents. But, staff showed an increased awareness of the risks associated with the garden at Oak Ward and the need to help keep young people safe. They had put in a process of regularly checking the garden to help minimise the risk.
- The records of observations were unclear, meaning that staff might not know how often individual observations were meant to take place.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards		Child and adolescent mental health wards have been rated as inadequate. For further information see the previous comprehensive inspection report published 30 July 2019.

Summary of findings

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Summary of this inspection

Background to Priory Hospital Blandford

Priory Hospital Blandford is an inpatient child and adolescent hospital for young people up to the age of 18 who have a learning disability or autism diagnosis as well as a mental health problem. The service is registered to provide treatment to young people detained under the Mental Health Act and treatment for disease disorder or injury. The service has 12 beds across the two wards; Oak and Ash.

The hospital opened in September 2018. There have been changes in the senior leadership team since opening and at the time of this inspection the provider was in the process of recruiting a hospital director. Senior staff from the wider Priory Group had been brought in to help promote improvement at the hospital.

The hospital was first inspected in May 2019 and was rated inadequate in the key questions for safe, effective, caring and well led, with responsive rated as requires improvement. Due to the inadequate rating, the service was placed in special measures by the commission. Services placed in special measures will be inspected again within six months. The service will be kept under review and, if needed, could be escalated to urgent enforcement action.

Due to the immediate concerns to safety we issued a section 29 warning notice that required the hospital to make immediate and thorough changes around the safety of their wards, management of risk and assessment of risk and the safety of the garden. Young people and staff told us that they did not feel safe at the hospital, there were high levels of assault on staff and young people told us that they felt degraded in their treatment.

Since May 2019, admissions to the hospital have been stopped by NHS England. At the time of the August 2019 inspection there were three young people admitted to the service.

Since the inspection in May 2019, the hospital has worked closely with stakeholders and commissioners to improve the care provided. There have been regular visits to the hospital and staff from the wider Priory Group have assisted the staff and managers working there.

During the August 2019 we found that although the provider had made some improvements to the service they had not met all the requirements of the warning notice.

Our inspection team

The inspection team comprised one CQC inspector, one inspection manager, a Mental Health Act reviewer, an expert by experience and a specialist advisor with specific experience in working in a child and adolescent mental health inpatient environment.

Why we carried out this inspection

CQC issued a section 29 warning notice to the hospital following a comprehensive inspection in May 2019. This focussed inspection was to check if improvements had been made.

Summary of this inspection

How we carried out this inspection

As this was a focussed inspection looking at improvement from a warning notice we did not inspect all key lines of enquiry. Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- spoke to the interim director, clinical services director and operations director
- spoke with the ward manager
- spoke with the social worker
- spoke with three nurses and three support workers
- spoke with two young people
- reviewed a range of meeting minutes and documents and
- reviewed the records for four young people.

What people who use the service say

During this inspection we spoke to two young people. Both young people told inspection staff that they felt safer on the wards than they had done previously. However, one young person said that they did not feel as safe at night due to some of the agency staff who did not interact with them.

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?

This was a focussed inspection so we did not rate this domain. We found that:

- The provider had improved the pre-admission assessment process to ensure they could meet their needs before admitting them to the service. The previous inspection had found that pre-admission assessments were not comprehensive enough to ensure all information about risks and the needs of young people was available to staff. The new process involved a face to face assessment by two members of the multi-disciplinary team, this was to ensure that young people had a full review of their needs and risk and that the service was appropriate to provide them safe and effective treatment. This amended assessment process had not yet been implemented as the hospital was not admitting new patients.
- Assessment and documentation of risk had improved. The previous inspection had found inadequate assessment of risk in the care records we reviewed. On this inspection we reviewed the documentation for all four of the young people admitted to the ward. The risk assessment and formulation were comprehensive in all the records reviewed.
- Staff managed the complex needs of the young people more effectively and incidents of restraint had reduced. The previous inspection found high use of physical restraint as an intervention. Staff we spoke with had felt an increased support from managers in this period and that they had worked hard together to follow the improvement plan for the site which included increasing confidence in managing risk on the wards.
- Staff had made treatment plans for medicines more explicit and there was a clear process within care plans for administering medications in line with this. The previous inspection had found as required medication (PRN) care plans lacked detail to support staff around the administration of these medicines, especially for young people prescribed multiple sedatives.

However:

- At the previous inspection there had been incidents where young people had been able to lift the bricks out of the patio which could be used to harm staff, other young people or themselves. At this inspection these bricks were still easy to lift out and were associated with ongoing incidents. But, staff

Summary of this inspection

showed an increased awareness of the risks associated with the garden at Oak Ward and the need to help keep young people safe. They had put in a process of regularly checking the garden to help minimise the risk.

- The records of observations were unclear, meaning that staff might not know how often individual observations were meant to take place.

Are services effective?

This was a focussed inspection, so we did not rate this domain. We found that:

- Staff had worked on improving the quality of the care plans for young people in the hospital.

Are services caring?

Since our inspection in May 2019 we have received no information that would make us re-inspect this key question.

Are services responsive?

Since our inspection in May 2019 we have received no information that would make us re-inspect this key question.

Are services well-led?

Since our inspection in May 2019 we have received no information that would make us re-inspect this key question.

Child and adolescent mental health wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are child and adolescent mental health wards safe?

Safe and clean environment

- Staff showed increased awareness of the risks of the garden at Oak Ward to help keep young people safe, however, there remained issues with safety. The previous inspection had found there had been incidents where young people had been able to lift the bricks out of the patio which could be used to harm staff, other young people or themselves. Staff had told us that young people found nails in the garden and had also used wood chips to self-harm. We reviewed incidents and found that staff had used restraint to prevent items being picked up in the garden, they had also used restraint to retrieve items taken from the garden. The issues in the garden were impacting on the behaviour of young people and therefore the response from the team. At this inspection, the garden for Oak ward continued to be a risk to the young people on the ward. Inspection staff easily dislodged bricks from the patio during the inspection. Staff reflected on a recent situation where they restrained a young person following the use of an item from the garden to self-harm. Staff showed increased awareness of the risks and practice had changed to monitor the Oak Ward garden for risks. There was a daily walk around to check the garden for risk items. Records showed that staff found nails and pieces of glass in the garden and that young people helped staff to scan the garden for risk items. The estates team had visited the service and a quote had been sourced to renovate the garden. There was a plan in place to make the garden safer however this was waiting for approval at a senior level. The provider could not provide a timeline for the improvements to take place by.

Assessing and managing risk to patients and staff

- The provider had improved the pre-admission assessment process to help identify appropriate admissions. The previous inspection had found that pre-admission assessments were not comprehensive enough to ensure all information about risks and needs of young people was available. Staff screened referral forms prior to accepting young people onto the ward, however, staff admitted young people that were not appropriate. Managers in the hospital had created a site improvement plan that included a review of the admission process and criteria. A new process had been put in place but was yet to be tested, due to the suspension of admissions. The new process involved a face to face assessment by two members of the multi-disciplinary team. This was to ensure that young people had a full review of their needs and risk and that the service was appropriate to provide them safe and effective treatment. The commissioners of the service had agreed this process.
- Staff assessment and documentation of risk had improved. The previous inspection had found inadequate assessment of risk in the care records we reviewed. On this inspection we reviewed the documentation for all four of the young people admitted to the ward. The risk assessment and formulation were comprehensive in all the records reviewed. There was a multidisciplinary team approach to risk assessment and the documentation incorporated a team approach to the assessment of risk. The hospital had brought in new guidance on how to assess risk and this was being followed by staff. The hospital had also started to use positive behavioural support plans to help staff manage young people's behaviours. However, there were discrepancies in the documentation of observations of young people. For example, it was unclear at times from reviewing the records whether young people were to be monitored once or twice per

hour. Staff had commenced a weekly audit of risk assessments to ensure that they were in line with the prescribed format, initial findings from the audits had found that they had improved. One member of staff was being trained as a trainer for risk assessment practice.

- Staff managed the young people's challenging behaviours more effectively. Staff spoke about understanding young people's risks and using positive behaviour support (PBS) in managing their risks. Staff stated that the situation had improved, and restraint was used less often. Staff and young people felt safer on the wards, although one young person said they did not feel as safe at night due to a lack of night staff interaction. Staff we spoke with had felt an increased support from managers in this period and that they had worked hard together to follow the improvement plan for the site which included increasing confidence in managing risk on the wards.

Medicines management

- Staff had made treatment plans for medicines more explicit and there was a clear process within care plans for administering medications in line with this. The previous inspection had found as required medication (PRN) care plans lacked detail to support staff around the administration of these medicines, especially for young people prescribed multiple sedatives. They did not contain information to direct staff to look at the positive behavioural support (PBS) plan before administration of PRN medicines. There was evidence of detailed medication care plans and the different medications to be given and in what order, there were also references to PBS plans and staff were stated that they tried to use these plans more readily to manage young people's behaviour. Staff documented rationale for administering PRN medication.

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- The quality of the care plans for young people in the hospital had improved. During the previous inspection we reviewed seven sets of care plans and found six that did not address risks or focus on recovery, they lacked detail and staff did not always follow them. Each young person had a keeping safe, keeping well, keeping connected and keeping healthy care plan. There was a large variation in the depth and quality of these care plans. This inspection found that care plans were generally of good quality, they included management of risks and focussed on elements of recovery with goals and interventions. Young people's involvement in the creation and updating of care plans was evident and there was evidence of an MDT approach to reviewing and updating the plans. There was variation in the way plans were written, some were written in the young person's voice and from their perspective while other were written descriptive and from the staff perspective.

Are child and adolescent mental health wards caring?

Since our inspection in May 2019 we have received no information that would make us re-inspect this key question.

Are child and adolescent mental health wards responsive to people's needs?
(for example, to feedback?)

Since our inspection in May 2019 we have received no information that would make us re-inspect this key question.

Are child and adolescent mental health wards well-led?

Since our inspection in May 2019 we have received no information that would make us re-inspect this key question.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that staff complete observation records clearly so that staff know how the observations need to be carried out for each patient.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	S29 Warning Notice The service had not met all the requirements of the warning notice issued following the previous inspection in May 2019. Aspects of the garden remained a risk to young people and the provider was unable to provide a timeframe for the improvements to take place. This remains a breach of Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.