St Mary's Hospital

Quality Report

St Mary's Hospital
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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?	Good

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.

Overall summary

We inspected St Mary's Hospital in line with our public commitment to reinspect any inadequate rating within six months of publication. We looked at the safe key question as this was rated inadequate following the March 2019 inspection. On this inspection we found that the provider had made significant changes and had made improvements to provide safe care and treatment. We therefore reviewed the ratings for the safe key question on this inspection from inadequate to good.

Summary of findings

We continued to rate St Mary's Hospital as requires improvement because at the last inspection we rated four key questions as requires improvement (effective, caring, responsive and well led) and now the safe key question was good.

On our inspection in July 2019, we found that the provider had met the requirements of the warning notice relating to medicines management.

On this inspection we found that

- The provider sustained the improvements we saw in July 2019 as staff reviewed and recorded blood results for patients on Lithium and Clozapine.
- Managers had made improvements and met the requirement notices relating to the safe key question. Staff completed a risk assessment of each patient at admission and reviewed risk assessments on an ongoing basis. There were sufficient numbers of nursing staff trained at the required level of British Sign language and/or sign language interpreters working on the four-bed ward for deaf patients. Patients on Cavendish, Dalston and Adams wards had a written positive behavioural support plan to provide staff with guidance on how best to support patients to reduce disturbed behaviour. Leo and Hopkins wards continued to have exemplary positive behavioural support plans.
- The service provided safe care. The ward environments were safe and clean. Staff managed medicines safely and took action to address the minor shortfalls in medicines management we found.
- Managers were working to improve staff vacancy rates.
- Staff had the skills required to provide safe care as staff mandatory training levels had improved significantly.
- Patients were not subject to blanket restrictions; where restrictions were in place, these were individually assessed.
- Managers used a computerised dashboard which provided them with very detailed safety incident data for each ward.

However:

- Staff had not updated the written care plans to fully reflect the care and treatment that patients with hepatitis had actually received.
- Seclusion was not used regularly but there were a small number of gaps in the separate seclusion records but the written daily record provided assurance that the safeguards were met.
- Staff and operational managers could not always fully articulate local lessons learnt following incidents.

Summary of findings

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Requires improvement

Location name here

Services we looked at

- Wards for people with learning disabilities or autism
- Services for people with acquired brain injury

Summary of this inspection

Background to St Mary's Hospital

St Mary's Hospital is based in Warrington and provides specialist services for people with acquired brain injury, autistic spectrum conditions or both. It is part of the Elysium Healthcare group, which also has other mental health and learning disability hospitals across England.

St Mary's Hospital is a 67 bed hospital which has five wards:

- Cavendish ward, a 17 bed locked rehabilitation ward for men with an acquired brain injury, serving as a step down from low secure services.
- Adams Ward, a 12 bed medium secure ward for men with an acquired brain injury with an additional four bed unit attached for people who are also hearing impaired.
- Dalston ward, an 18 bed low secure ward for men with an acquired brain injury.
- Leo ward, a 12 bed locked ward for men with autistic spectrum disorder. Patients on the unit have a primary diagnosis of an autistic spectrum disorder often accompanied by co-morbid conditions and/or a history of challenging behaviour.
- Hopkins ward, a four bed locked ward for women with autistic spectrum disorder. Patients on the unit have a primary diagnosis of an autistic spectrum disorder often accompanied by co-morbid conditions and/or a history of challenging behaviour. Leo and Hopkins wards were next to each other and worked together under the same ward manager and staff group.

There is a registered manager, accountable officer and nominated individual for this location.

The service is registered to provide the following regulated activities:

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

NHS England and regional specialist commissioners fund the care of patients in the medium and low secure wards. The local clinical commissioning group funds patients admitted to the non-secure services. St Mary's Hospital accepts referrals from across the United Kingdom and from Ireland.

This is the third time we have inspected the St Mary's hospital since it has been managed and overseen by the Elysium Healthcare group. The Elysium Healthcare group took over the running of St Mary's Hospital in August 2018.

- We inspected in March 2019 and we rated four key questions as requires improvement (effective, caring, responsive and well led) and one key question (safe) as inadequate. We issued a warning notice in relation to regulation 12 - safe care and treatment relating to the management of medicines and a number of requirement notices.
- We returned in July 2019 to check whether the requirements of the warning notice had been met. We found that improvements had been made and the warning notice had been met.
- On this inspection, we checked whether the improvements had been made to the concerns relating to the safe key question in line with our public commitment to reinspect any inadequate rating within six months of publication. On this inspection, we found that the provider had taken sufficient action to address the requirement notices relating to safety.

We have reported and rated all the wards at St Mary's Hospital together within this report. The report includes both the wards for patients with acquired brain injury together with the wards for people with autism, due to the relatively low number of beds on the wards for patients with autism.

Summary of this inspection

Our inspection team

The team that inspected the service comprised two CQC inspectors, a CQC inspection manager, and one specialist advisor (a nurse).

We were also assisted by a sign language interpreter who helped us to communicate with patients who were deaf.

Why we carried out this inspection

We inspected this service as part of our on-going mental health inspection programme and our commitment to inspect all services within six months of a published rating of inadequate in any key question.

How we carried out this inspection

On this inspection, we assessed whether the service had made improvements in response to the concerns we identified during our last comprehensive inspection aligned to the safe key

We therefore inspected the following key question:

• Is it safe?

This inspection was short-notice announced, which means that the provider was told we were coming one working day before we arrived. Before the inspection visit, we reviewed information that we had gathered about the location and requested additional information from the provider.

During the inspection visit, the inspection team:

- visited all the wards and looked at the quality of the ward environment
- spoke with 15 patients
- spoke with managers for each of the wards
- spoke with twelve other staff members from different disciplines including nursing, recovery worker and social work staff
- interviewed the service director and lead nurse
- looked at fifteen patients' care and treatment records including communication and health passports, positive behavioural support plans and care and treatment review meeting records
- reviewed restraint and seclusion records
- attended a multi-agency quality monitoring meeting
- looked at medicine charts including looking at the monitoring of patients' physical health and checking that patients on high dose antipsychotic medication received appropriate monitoring.
- looked at a range of policies, procedures and other records relating to the running of the service.

What people who use the service say

We spoke with 15 patients. The feedback we received from patients was largely positive. Many patients were complimentary about the care they received from the staff on the wards. Most patients told us there were enough staff to care for them and staff treated them with dignity and respect. Where patients made less positive comments, it was often due to being detained in hospital and the associated restrictions on their liberty.

Patients told us that the hospital was kept clean. Most patients said there were enough staff to provide care including activities and to provide escorted leave. Two patients said that sometimes groups were cancelled or rearranged for another day due to the lack of permanent staff on the one ward. Two deaf patients we interviewed

Summary of this inspection

commented that there were now enough staff who could communicate using sign language to an appropriate standard. The hospital did bring interpreters in more regularly as well.

Patients said they felt safe on the wards. Some patients said they sometimes faced verbal or physical abuse from other patients but staff did their best to keep patients safe from others.

Patients told us they were given information about their medication in a way they understood. One patient who had been restrained said that staff carried out the restraint in a caring way and spoke with him afterwards about the restraint.

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?

Good

Our rating of the safe key question improved. We rated it as good because:

- Managers had acted to address the requirement notices we issued in March 2019.
- Staff completed a risk assessment of each patient at admission and reviewed risk assessments on an ongoing basis including relevant patients having a detailed forensic risk assessment.
- Patients who were deaf had better access to staff who could communicate with them through an increase in interpreting support and more staff undertaking British Sign Language training.
- Patients had either a detailed positive behavioural support plan and/or a two-page profile to guide staff in how patients should be supported and help avoid and manage challenging behaviour. Leo and Hopkins continued to have exemplary positive behavioural support plans.
- Staff had sustained the improvements to the recording and checking of blood tests of patients on Lithium and Clozapine which was an important part of patients receiving these treatments safely.
- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received training to keep patients safe from avoidable harm. Managers were continuing to improve ward staff vacancy rates following the transition to Elysium Healthcare and used regular agency staff.
- Managers had appropriate systems to make sure only staff of good character were recruited to work at the hospital.
- Staff were positive about the revised mandatory training which improved their understanding of caring for patients with autism, acquired brain injury and Huntingdon's Disease.
- Staff achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. The ward staff participated in the provider's restrictive interventions reduction programme.

Summary of this inspection

- Staff understood how to protect patients from abuse and the service had further improved its' work with other agencies to do so. Managers took appropriate action on safeguarding incidents including identifying systemic action to prevent a reoccurrence.
- The service used systems and processes to safely prescribe, administer, record and store medicines. The provider acted to quickly address to minor shortfalls we found including medical equipment or medicines we found which were just out-of-date and shorter-life medication which was not labelled on opening.
- Staff regularly reviewed the effects of medications on each patient's physical health. Staff worked towards achieving the aims of the STOMP programme (stop over-medicating people with a learning disability).
- Staff had easy access to clinical information and it was easy to maintain high quality clinical records through full implementation of an electronic record system.
- The wards had a good track record on safety. Staff recognised incidents and reported them appropriately.
- Managers had good oversight of safety and risk through the ward dashboards which identified shortfalls and patterns so appropriate action could be taken to mitigate these.

However:

- Staff had not updated the written care plans to fully reflect the care and treatment that patients with hepatitis had actually received.
- Seclusion was not used regularly but there were a small number of gaps in the separate seclusion records but the written daily record provided assurance that the safeguards were met.
- Staff and operational managers could not always fully articulate local lessons learnt following incidents.

Detailed findings from this inspection

Requires improvement

Services for people with acquired brain injury

Safe	Good

Are services for people with acquired brain injury safe?

Good

Safe and clean environment

The ward environments were safe and clean. All the wards offered single bedrooms with full en-suite facilities in each bedroom. On each ward, there was a clinic room, a range of other rooms and enclosed courtyards attached. Managers continued with a programme of environmental improvements since Elysium Healthcare took over the running of the hospital including redecoration and a new car park.

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Staff had completed recent, comprehensive ligature risk assessments. The assessments included details of any amendments that were required to the ward environments and action to mitigate the risks in the interim. Each ward had a security nurse allocated on each shift. The security nurse checked the designated risk areas on the wards regularly. These checks were in addition to patient observations that were allocated to other members of staff.

Staff could observe patients in all parts of the wards. There were good lines of sight through the wards. Where there were blind spots, which hindered staff observing patients, there were mirrors at height to help staff have a view of blind spots. Managers had recently audited blind spots and were looking to improve further lines of sight into blind spots. There was closed circuit television in communal areas which could be viewed retrospectively for incidents. Patients were informed about the presence of closed-circuit television.

The ward complied with guidance and there was no mixed sex accommodation. All the wards only admitted either male or female patients. There were no breaches of mixed sex accommodation guidance within this service.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Many of the significant ligature risks had been removed and curtain and shower rails were fully collapsible throughout the wards. Toilet, shower and bathroom fittings in patient bedrooms were anti-ligature. Some fittings such as taps on handwashing sinks in communal areas were not fully anti-ligature. Staff were mitigating the risks of ligatures on the wards through staffing levels and patient observations.

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

Ward areas were clean, well maintained, well-furnished and fit for purpose. All ward areas were maintained to a good standard with comfortable furnishings throughout the hospital. Following three incidents, the provider identified an issue where viewing panels in internal doors had been damaged by patients and had come away from the door as a result of disturbed behaviour. The viewing panel units required significant force to fall out in this way. The whole panel fell out and the glass was reinforced so did not shatter. The three incidents did not result in any harm to staff or patients. When replacing damaged units, managers were now using a different supplier who supplied and fitted a more robust panel. Managers were risk assessing viewing panels, and where there was a risk of damage, replacing these.

Staff made sure cleaning records were up-to-date and the premises were clean. During the inspection, hospital cleaners were working on the wards and the wards were visibly clean.

Staff followed infection control policy, including hand washing.

Seclusion room

The hospital had one seclusion suite. The seclusion suite was based on a quiet corridor between the two different parts of the hospital, so it could be utilised by any ward in the hospital. If a patient presented with significant behavioural disturbance and could not be conveyed from the ward to the seclusion suite, staff used cleared rooms on

the ward while ensuring the required safeguards were still met. There had not been any incidents relating to when patients were conveyed to the seclusion room from the wards.

The seclusion room allowed clear observation and two-way communication. The viewing panel in the seclusion room door permitted staff to carry out observations. Managers had adapted the side panel window which permitted staff to observe patients in the bathroom to make sure observations could be done more discretely and maximise patients' privacy. Patients had a working intercom system so they could speak with staff while in seclusion.

It had a separate toilet and shower room which could be accessed by patients without having to come out of seclusion. The taps in the sink and shower of the seclusion suites were anti-ligature.

It had a clock outside the seclusion room so patients that were secluded could remain oriented to time. It had heating and ventilation which was controlled from a panel outside the seclusion room. It had a tear-proof, seclusion mattress, which afforded comfort especially during longer periods of seclusion.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Ward treatment rooms and refrigerators were properly monitored by ward and pharmacy staff to ensure that medicines were stored at the correct temperature and were safe to use. Emergency bags were available which included resuscitation equipment and emergency drugs. Staff checked these daily to ensure that all equipment was in date and fit for purpose.

Staff checked, maintained and cleaned equipment.

Safe staffing

The service did not have enough permanent staff with the right skills, qualifications and experience for each shift as there were a number of nurse vacancies. However, managers had a strategy to improve this and deployed regular bank and agency staff as an interim measure. Elysium Healthcare took over the running of St Mary's Hospital in August 2018 and inherited a high nursing vacancy rate. During the transition, some staff decided to leave and the provider also increased the staffing establishment. This led to the hospital having further vacancies.

The core staffing levels on each shift were as follows:

- On Dalston and Adams wards, there were two registered nursing staff and seven recovery workers on days; on nights, they worked on two registered nurses and six recovery workers.
- On Cavendish and Leo/Hopkins wards, there were two registered nursing staff and seven recovery workers on days; on nights, they worked on one registered nurse and five recovery workers.

On inspection, we saw that these core numbers were met and the wards had higher staffing levels due to the numbers of patients requiring observations.

The service had reducing vacancy rates. There were a number of registered nurse vacancies but this had improved consistently since Elysium took over the running of the hospital (40% vacancy rate for registered nursing staff at November 2019, improved from 45% in March 2019 and 59% in November 2018).

At the time of the inspection, the vacancy rate for registered nursing staff per ward at St Mary's Hospital was:

- Adams ward - five full-time establishment registered nurse vacancies - 50% (down from 60% in March 2019)
- Cavendish ward – three and a half full time establishment registered nurse vacancies – 46% (down from 50% in March 2019)
- Dalston ward - three full-time establishment registered nurse vacancies - 33% (down from 45% in March 2019)
- Leo and Hopkins ward – two and a half full-time establishment registered nurse vacancies - 33% (down from 65% in March 2019)

The vacancy rate for non-registered nursing staff per ward at St Mary's Hospital was:

- Adams ward – 0.7 full-time establishment recovery worker vacancies - 2% (down from 18% in March 2019)
- Cavendish ward - 2.7 full-time establishment recovery worker vacancies - 9% (up from 0% in March 2019)
- Dalston ward – 2.3 full-time establishment recovery worker vacancies - 7% (up from 0% in March 2019)
- Leo/Hopkins ward – 1.4 full-time establishment recovery worker vacancies - 5%. (down from 21% in March 2019)

Requires improvement

Services for people with acquired brain injury

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers had implemented Elysium's safe staffing procedures which meant that there was now an automatic escalation and notification to managers where staffing did not reflect planned numbers so that managers could act to address any shortfall and the team was supported by a senior member of staff. There were also further interviews for both registered and non-registered staff in the pipeline.

Managers confirmed they had made the following offers which have been accepted:

- Five registered nurses were awaiting start dates and a further five registered nurses recruited were trained outside of the European Union and were undergoing the objective structured clinical examination to be registered as nurses in England. If all of these registered nursing staff were retained, this would lead to a vacancy rate of 13% for registered nurses.
- 20 recovery workers were awaiting a start date and the provider intended to recruit 50 recovery workers above budgeted numbers due to the regular and routine additional observations required to reduce reliance on agency staff.

The staffing of St Mary's Hospital was highlighted on the risk register from when Elysium Healthcare took over and had been included in the risk register from July 2015. This risk remained on the risk register at the time of this inspection in November 2019. With the controls in place to reduce or mitigate the risks, the provider identified that the residual risk score had improved mainly due to improved nurse recruitment.

We asked managers about the impact of staffing and specifically requested the numbers and details of incidents categorised as occurring due to short or critical staffing levels as a primary or secondary factor for the period 2019. The provider told us that there had been two incidents from 1 September 2019 to 2 December 2019. Neither incident lead to harm of patients and in one case, additional staff were found, and the shift was adequately covered part way through the shift.

From looking at incidents, care records and through speaking to staff and patients, we did not identify any critical concerns about the quality of care being compromised due to the qualified staff vacancy rates and high use of bank and agency staff deployed while managers recruited substantive staff.

The arrangements for staff who could communicate with deaf patients had improved. The hospital had increased the time they brought in interpreters from 2.5 days to 4.5 days during weekdays to support patients with formal meetings such as ward rounds and care programme meetings as well as at other time for activities and more general communication.

The number of staff deployed to work with deaf patients who could sign to a competent level had improved. The NHS standardised contract for specialist mental health services for deaf people stated that all staff should be supported to develop British Sign Language level two as a minimum and it was desirable to be trained to level three, especially expert clinical staff. Managers confirmed that there were 19 staff trained to British Sign Language level one (two registered staff and 17 non-registered staff), six staff to British Sign Language level two (one consultant psychiatrist, one registered staff and four non-registered staff) and a further five staff completing level two training. There was one non-registered nursing staff with level six training. Managers at the hospital were supporting staff to develop signing skills and encouraging higher level training. Together with the deployment of signing staff and the improved contracted interpreter service, deaf patients could now communicate effectively with staff about their care and treatment.

Both deaf patients we interviewed commented that there were now enough staff who could communicate using sign language to an appropriate standard. The hospital did bring interpreters in more regularly as well. The patients told us that most times they could communicate in British Sign Language.

While managers used bank and agency staff regularly, they requested and used staff familiar with the service. There was a heavy reliance on agency registered nursing staff largely due to nurse vacancies. Agency recovery worker staff were largely used for observations. Between September and December 2019, agency staff accounted for between 27% and 29% of all staff on shift. It was very rare for shifts not to be filled through utilising regular staff being flexible, bank and agency staff.

Requires improvement

Services for people with acquired brain injury

Managers made sure all bank and agency staff had an induction and understood the service before starting their shift. Elysium Healthcare had its own bank staff system. Bank staff were provided with induction and annual refresher training to be effective in their role. Regular nursing agency staff were block booked and, where possible, were familiar with the patients. External agency staff had a safety briefing at the start of the shift that included detailed information about patients, their risks and needs and the ward environment. Managers identified difficulties in securing agency registered nurses on a Sunday so had identified nursing agencies from a wider geographical spread to help secure registered nurses more easily.

The ward managers could adjust staffing levels according to the needs of the patients.

Managers supported staff who needed time off for ill health and helped to keep sickness rates low. The sickness levels for each ward were as follows: -

- Adams ward: September 2019 - 3%; October 2019 - 1%, November 2%
- Cavendish ward: September 2019 - 4%; October 2019 - 5%, November 5%
- Dalston ward: September 2019 - 5%; October 2019 - 3%, November 3%
- Leo and Hopkins ward: September 2019 - 3%; October 2019 - 2%, November 3%

This meant that sickness rates on most wards were lower when compared to an England average of 4.9% sickness rate for mental health and learning disability hospitals according to the most recent annual figures (for the year 2018/9). This compared to figures prior to the last comprehensive inspection in March 2019 where they were consistently above the England average.

Patients had regular one to one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the ward was short staffed. Staff prioritised patient leave and the deployment of staff on the shift was discussed each morning. Sometimes leave or activities were rescheduled for the same day when there were not enough staff to escort patients.

The service had enough staff on each shift to carry out any physical interventions safely. Most patients on the wards required additional observations. There were a significant number of additional recovery workers to provide observations where patients required additional observations due to their physical or mental health.

Staff shared key information to keep patients safe when handing over their care to others.

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There were four doctors at the hospital including consultant psychiatrists and a consultant neuropsychiatrist out of a complement of five doctors. The hospital were recruiting to the one doctor vacancy - a staff grade doctor following a recent resignation. The hospital also contracted with a local GP service that offered extended hours appointments and visits to the hospital. There was a rota for out of hours cover. We did not identify any concerns regarding delays in doctors attending the hospital when needed. For example, seclusion records showed doctors attending quickly. Managers could call locums when they needed additional medical cover.

Managers were making appropriate checks to make sure staff were of good character. We looked at the personnel and recruitment files for two members of staff. Records showed that appropriate recruitment checks were made including completing disclosure and barring service checks and the verification of identity, qualifications and professional status before staff started working at the hospital.

Staff had completed and kept up-to-date with their mandatory training.

The compliance for mandatory and statutory training courses at 1 December 2019 was 92%. The provider set a target of 90% for completion of mandatory and statutory training.

Of the mandatory training courses, four out of 21 mandatory training courses failed to achieve the provider target of 90%. However, all of the mandatory training scored above 75%.

The training compliance reported for this core service during this inspection was much higher than we last inspected in March 2019. At March 2019, the mandatory training uptake figures showed that all but one of the training courses failed to achieve the provider target and of those, only four out of 21 were above 75% uptake.

Requires improvement

Services for people with acquired brain injury

Managers had put effort to ensure staff completed mandatory training, they had put on extra courses and also included training as a critical issue in their transition assurance plan to improve staff take up of mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff. Staff had access to training on acquired brain injury, autism and learning disability as part of their core training. Senior staff had undertaken Huntington's disease awareness training. All staff were in in the process of completing three-day acquired brain injury awareness training and the provider had arranged an autism experiential learning event in December 2019.

Managers monitored mandatory training and alerted staff when they needed to update their training. The ward dashboards identified training uptake figures and ward managers took action where training was due or overdue for renewal.

Assessing and managing risk to patients and staff

Staff completed risk assessments for each patient on admission / arrival, and reviewed these regularly, including after incidents.

In March 2019, we found that staff had not always fully completed formal risk assessments initially when the patient was admitted to the hospital and staff had not always detailed how risks should be mitigated in the written plans of care. On that inspection, we therefore found the hospital breached regulations in relation to providing safe care to patients.

On this inspection, staff now completed a risk assessment for each patient when they were admitted and reviewed risk assessments regularly. We looked at risk assessments for fifteen patients. Patients had up-to-date risk assessments which identified the risks patients posed to themselves or others with risk management plans in place. Staff had completed a detailed forensic risk assessment for relevant patients

In March 2019, we found that staff had not assessed or managed behaviour that challenged others effectively using consistent positive behavioural support approaches. On that inspection, we therefore found the hospital breached regulations in relation to providing safe care to patients.

On this inspection, staff now completed a detailed positive behavioural support plan and/or a two-page profile to guide staff in how patients should be supported and help avoid and manage challenging behaviour. While most positive behavioural support plan and two-page profiles were individualised and detailed, a small number of two-page profiles did not fully reflect the staff's detailed understanding of each patient and could have contained more information. However, overall it was much improved. In particular, Leo and Hopkins continued to have exemplary positive behavioural support plans guided by a lead positive behaviour support practitioner that had spoken internationally on the subject.

Staff used a recognised risk assessment tool. Staff used the historical clinical risk management 20 (widely known as HCR-20) tool and short-term assessment of risk and treatability risk assessment tools. The historical clinical risk management 20 tool is a comprehensive set of professional guidelines for the assessment and management of risk relating to offending history.

Staff knew about any risks to each patient and acted to prevent or reduce risks. Where patients had physical health problems that could present with risks that needed to be managed these were well documented. For example, we saw where patients were on high dose anti-psychotics were supported with physical health observations regularly to check for side effects and for those patients at risk of over hydration (polydipsia), their care plan included individualised support around drinks to manage the risks.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff now reviewed risk assessments for each patient on a monthly basis. The only exception was that staff had not updated the written care plans to fully reflect the care and treatment that three patients with hepatitis had actually received. Other records identified that these patients were receiving appropriate treatment including anti-viral treatment, liver function tests and ongoing input from a consultant haematologist but the care plan only had basic details of patients' hepatitis status. Managers told us that the care plans for each of these patients was reviewed to fully reflect the care and treatment being received.

Staff followed hospital policies and procedures when they needed to search patients or patients' bedrooms to keep them safe from harm. Staff carried out random and specific

searches on patients on the secure wards and worked within a policy on searching. Most patients were on 1:1 observation levels which meant that staff were with them at all times.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff had received training on reducing restrictive practice. Restrictions on patients' belongings were kept to a minimum. For example, patients across the hospital were allowed their own mobile phone. The only exception was where this had been risk assessed for individual patients on clinical or security grounds.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The ward manager of Leo ward was actively involved in the national reducing restraint network and spoke at their last conference. Managers could access a computer-based dashboard for each ward which was used to monitor and analyse information about the use of restrictive interventions such as restraint and seclusion pulled from the electronic incident record system. Managers discussed reducing restrictive practice at monthly hospital governance meetings by monitoring levels of physical restraint and where necessary developing action plans to address any issues.

Staff made every attempt to avoid using restraint by using de-escalation techniques and only restrained patients when these failed and when necessary to keep the patient or others safe. Staff understood the Mental Capacity Act definition of restraint and, where appropriate, worked within it.

Over the 3 months prior to the inspection, incidences of restraint were as follows:

- September 2019 – 114 episodes
- October 2019 – 119 episodes
- November 2019 – 78 episodes

Restraint episodes included episodes where staff put hands on to support personal care to patients and also to prevent injury for patients whose behavioural disturbance was a persistent feature.

The reduction in restraint in November 2019 also coincided with a rise in early intervention being recorded – from 150 episodes in September 2019 to 211 episodes in November 2019. Managers reported that this was likely to be due to be improved training in restraint and also on patients' conditions such as autism and acquired brain injury.

Staff followed NICE guidance when using rapid tranquilisation. On occasions, patients may be prescribed medicines known as rapid tranquillisation to help with extreme episodes of agitation, anxiety and sometimes violence. Following rapid tranquillisation, nursing staff were required to record regular observations of the patient's blood pressure, temperature, oxygen saturation and respiratory rate. The corresponding care records for patients who had been given rapid tranquillisation showed clearly that staff recorded the reasons for giving rapid tranquilisation and had recorded observations. Where patients declined these checks, staff completed checks based on visual observations.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. There had been five episodes of seclusion for the three-month period prior to the inspection. Records showed that on each ward, seclusion was not used frequently, and where it was used it was often used for short periods of less than four hours. On the inspection, we reviewed three individual record of seclusion. There were a small number of gaps in the separate seclusion records. For example, the rationale for seclusion being required, the time the doctor attended or the multidisciplinary review was not always recorded on the records we saw. However, the corresponding written daily record provided a record and the assurance that the safeguards were met. Following our feedback to managers, they prompted all staff to complete all sections of the seclusion booklet and would look at this issue in detail during a forthcoming planned audit of seclusion paperwork.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. Long term segregation was not used frequently and there was one episode of long-term segregation at the time of the inspection. We did not have the opportunity to review the long-term segregation record in detail but saw that that an independent review had been carried out.

Safeguarding

Requires improvement

Services for people with acquired brain injury

Staff received training on how to recognise and report abuse, appropriate for their role. Training in safeguarding adults and safeguarding children was mandatory and required staff to attend initial and regular refresher training. Across the hospital, 96% of staff were up-to-date with their safeguarding adults training – which had improved from 50% when we inspected in March 2019.

Staff kept up-to-date with their safeguarding training. The hospital had an interim lead social worker who provided advise to staff on their responsibilities.

Staff could give clear examples of how to protect patients from harassment and discrimination. Staff we spoke with had a good understanding of safeguarding procedures and what to do when faced with a safeguarding concern.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The hospital had notified us of safeguarding incidents. In each of the safeguarding cases, it was clear that the hospital had taken appropriate action to safeguard vulnerable patients. When the staff in the hospital were in doubt, they informed us they would speak to local authority staff for guidance on whether a referral was necessary.

Where safeguarding incidents included verbal or physical abuse between patients, managers accepted that they would benefit from clear, written criteria around thresholds for referrals agreed with the local authority.

Staff followed clear procedures to keep children visiting the ward safe. There was a well-equipped family visiting room off the ward areas so children could visit patients without going on the wards. The hospital's social workers assessed the appropriateness of children visiting patients. They liaised with relevant authorities and made the arrangements for child visiting where this was deemed to be in the best interests of the child.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital had recently recruited social workers who had established improved working relations with the local authority safeguarding team and checked that appropriate and timely action was taken to protect vulnerable adults. For example, the hospital social worker had requested that a safeguarding strategy meeting was convened for one patient to protect them from abuse.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

We reviewed recent safeguarding incident investigations. We saw that there was evidence to show that within investigations staff acted promptly to raise safeguarding incidents and speak out. Each incident was considered and investigated by a senior member of clinical staff. Where safeguarding incidents concerned allegations against staff, we saw that managers took action and now looked further than personnel factors when looking at the incident including considering wider root cause analysis, organisational and systemic factors as part of their local investigations.

In August 2019, we inspected St Mary's Hospital and looked at safeguarding as managers had not notified us of four of safeguarding incidents. Managers recognised that they should have notified us and accepted that their systems were not effective.

Managers had now further improved their systems to ensure that CQC were properly notified of safeguarding incidents. The lead social worker reviewed safeguarding incidents, kept a safeguarding spreadsheet to monitor incidents and proactively liaised with the local authority, where appropriate. Managers discussed safeguarding incidents at each morning meeting which included improved flagging systems to ensure we were notified. The hospital also had a new lead nurse who ensured that the hospital met its' safeguarding responsibilities fully.

Staff access to essential information

Patient notes were comprehensive and all staff could access them easily. Elysium Healthcare had introduced an electronic care notes system which was fully implemented

at the time of the inspection. Patient records now completed electronically by staff or scanned in. Elysium had a standardised filing system within their electronic database.

Records were stored securely on password protected computers and applications.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Eighty-nine per cent of relevant staff had completed medicines level one training. Eighty per cent of relevant staff had completed higher level medicines level two training. We saw that following audits from the pharmacist, staff had taken action to address any areas identified to ensure safe prescribing, administering, recording and storing medicines

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We reviewed medicines charts and patient records in detail and found staff kept accurate records of the treatment patients received, except in a very small number of minor cases. These included a small number of medicine charts with a small number of isolated missing doses of non-critical medication with no corresponding explanation.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff ensured medicines including controlled drugs were securely stored and emergency medicines were regularly checked to ensure they were available if needed. Clinic and fridge temperatures were monitored to make sure that medicines were stored at correct temperatures. However, we found minor shortfalls. We saw a small number of non-medicine items (empty vials) in the ward clinic rooms which had expired but were not in use. This was because the arrangements for taking bloods and other samples now took place in a clinic room off the ward but the old stock had not been disposed of. We also saw that a small number of recently expired medicines which were not being used had not been disposed of appropriately. For example, medicines relating to patients discharged from St Mary's Hospital. We highlighted these to the ward manager or senior nurse in charge and they acted immediately to address these minor shortfalls. In addition, managers had also ensured that posters were displayed in the clinic rooms prompting staff to remove out of date medication and equipment and the clinic room audit was amended to include a check for out-of-date medication.

Staff followed current national practice to check patients had the correct medicines. We reviewed consent to treatment documentation and found medicines were prescribed in accordance with the provisions of the Mental Health Act. We also found that the legal certificates authorising treatment for mental disorder for detained patients were kept with the medicine chart as required by the Mental Health Act Code of Practice. This meant that staff administering medicines could check that they had the appropriate paperwork and legal authority to give medication to detained patients at the time the medicine was given.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We saw safety alerts in clinic rooms and also medical alerts were routinely discussed as a standard agenda item in monthly governance meetings and disseminated to staff as required.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both). Doctors reviewed patients' medication regularly and, where possible, patients were not on anti-psychotic medication or had significantly reduced the dose while at St Mary's Hospital. This was in line with national guidance on the stopping over medication of people with a learning disability, autism or both commonly known as STOMP.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. We reviewed physical health monitoring for patients who were prescribed antipsychotic medicines. A physical health assessment was completed when patients were admitted. Staff kept records of investigations and physical observations in patients' medical notes. In general, we found monitoring had been completed in accordance with national guidance and the hospital policy.

The systems in place for managing medicines minimised risks or keep patients safe. The hospital had a healthcare support worker to help oversee that all necessary physical

health checks, including blood tests were properly requested, acted upon and recorded. Some patients were prescribed medicine that required regular monitoring of blood levels to ensure that ongoing treatment for their mental disorder was safe, such as Lithium or Clozapine treatment. We saw monitoring had been completed at the appropriate intervals. There was now a properly effective recording system to provide assurances to managers and prescribing clinicians that these essential blood results were requested or followed up in a timely manner.

The required regularity of blood retesting was recorded in relevant patients' current care plans to guide and remind staff. Staff also produced an individualised patient specific Clozapine or Lithium care plan for relevant patients. The blood results were scanned in when received and a doctor's review was recorded electronically and each result was clearly marked to show why blood was taken. This helped to check that blood results had been taken, reviewed and appropriate action taken.

Track record on safety

We looked at the incidents that had occurred recently at this hospital. All independent hospitals were required to submit notifications of significant incidents to us. Between 1 March 2019 and 1 December 2019, the hospital had notified us of 24 relevant events including safeguarding incidents.

Between 1 March 2019 and 1 December 2019 there had been no deaths or severe incidents reported by this service. There had been four incidents categorised as high – two relating to patients which required attendance at an emergency department due to physical health concerns, one injury by staff following a patient assault and one damage to property. Of the total number of incidents reported, the most common type of incident was 'no harm' incidents which made up 65% of incidents reported.

Following any death where there had been an inquest, local coroners may issue a report with the intention of learning lessons from the cause of death and preventing deaths. There had been no reports to prevent future deaths issued by the coroner in the 12 months up to the inspection for St Mary's Hospital. There was one patient death from 2016 which was still to be considered by the local coroner.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Elysium Healthcare had a standard system of incident monitoring. Staff we spoke with understood the types of incidents to report.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff reported serious incidents clearly and in line with trust policy. Staff completed reports for incidents and near misses on the provider's computerised incident reporting system. Ninety-four per cent of incidents were reported within 24 hours. Senior managers reviewed incidents entries each day at the morning meeting where decisions were made regarding any further action which may be required. This could include referral to safeguarding, further investigation or reporting as a serious untoward incident.

The service had no never events on any wards. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. In mental health services, the relevant never event within hospital settings was actual or attempted suicide of a patient due to the failure to install functional collapsible shower or curtain rails and falling from an unrestricted window.

Staff understood duty of candour. They were open, transparent and gave patients a full explanation when things went wrong. Managers and staff were aware of their responsibilities in relation to duty of candour which required staff to be open and offer an apology when an incident occurred resulting in serious patient harm. There had been no incidents where the serious harm threshold had been met.

Managers debriefed and supported staff after any serious incident. Senior managers, doctors and ward managers attended a daily morning handover meeting where incidents were reviewed and actions planned. Once a week, the handover reviewed actions overall to ensure a broad view of issues across the hospital and incidents were maintained. Clinical psychologists offered debrief sessions immediately following serious incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers had access to a range of performance indicators through a computerised dashboard which provided information for incidents on each ward including numbers, types and categories of incidents, the timeliness of

recording incidents, analysis of the days and times when most incidents occurred, the types of injuries sustained and interventions used, where appropriate. Managers therefore had very detailed safety incident data for each ward. This could be accessed centrally by managers at the hospital and senior at provider level. Managers met weekly to ensure there were appropriate reviews of the dashboards and incidents at the hospital.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers discussed learning from incidents at the hospital's monthly operational and clinical governance meeting so that lessons learned which occurred within St Mary's Hospital and from across Elysium were shared with the staff team. This included a staff newsletter and a 'golden thread' lessons learned newsletter which was sent to staff.

Staff met to discuss the feedback and look at improvements to patient care. The recent 'golden thread' lessons learnt newsletter included briefings on the need to check grab bags, replace ligature cutter blades after use and the need for improved communication of changes to patients' presentation during and between shifts. On inspection, we found that despite these initiatives, staff and operational managers could not fully articulate local lessons learnt to us when we spoke with them on inspection. This was discussed at the hospital governance meeting soon after our inspection and managers were going to provide a simple update for staff each month which will be discussed in handovers and staff meetings to raise awareness of lessons learned.

There was evidence that changes had been made as a result of feedback. Managers acted quickly to address the shortfalls we found on inspection including acting to address minor medicines issues, care planning for patients with hepatitis, seclusion recording and disseminating lessons learnt.

Managers shared learning with their staff about never events or serious incidents that happened elsewhere. Following a patients' death by asphyxiation with a plastic bag at a nearby hospital, managers had controlled the use of plastic bags to prevent a reoccurrence.

Outstanding practice and areas for improvement

Outstanding practice

- Positive behavioural support approaches were truly embedded on Leo/Hopkins ward. Staff continued to complete positive behavioural support plans with patients to a very high standard with very detailed and individualised strategies. Staff working on the ward were passionate advocates for positive behavioural approaches led by the ward manager who had spoken nationally and internationally about reducing restraint and restrictive practices.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should make sure that staff update the written care plans to fully reflect the care and treatment that patients with hepatitis actually receive.
- The provider should make sure that staff complete the separate seclusion records fully to provide clear assurance that the safeguards were met.
- The provider should make sure that staff and operational managers understand and can communicate local lessons learnt following incidents.