

Southern Hill Limited

Southern Hill Hospital





Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement	
Are services safe?	Requires Improvement	
Are services effective?	Good	
Are services well-led?	Requires Improvement	

Summary of findings

Overall summary

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the service.

We inspected specific safe, effective and well-led selected key lines of enquiry for the service.

We rated safe and well-led domains as requiring improvement as breaches of regulation were found. The effective domain was rated as good. We did not inspect the caring and responsive domains. The overall rating for this service is requires improvement. The previous rating of good for the domains caring and responsive remain. The report for the previous inspection can be found here:

Southern Hill Hospital (cqc.org.uk)

We found the following areas the provider needs to improve:


- Staff did not always follow the provider's use of rapid tranquilisation policy.
- Incidents were recorded and actions documented, however it was not clear from the documentation and staff meeting records if lessons learnt from incidents had been considered or shared with the staff team as this had not been recorded.
- There was a lack of information for patients informing them of their rights displayed within the wards, however managers advised that patients are given a booklet on admission telling them about their rights.
- Some areas of the wards needed redecoration.

However:

- At the time of inspection, we did not find that all records had been completed. However, following inspection the service provided evidence of a physical health check audit for 175 patients demonstrating the provider had followed its' own policy and National Institute for Health and Care Excellence (NICE) guidance.
- Physical interventions were used as a last resort and the patient safety officer team provided regular and consistent support to staff on each ward. The service was also part of the restraint reduction network.
- Staff had completed and were kept up-to-date with their mandatory training. All compliance rates for mandatory training courses were above the hospital target of 85%.

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 	

Summary of findings

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Summary of this inspection

Background to Southern Hill Hospital

Southern Hill Hospital is an independent mental health care facility located close to the North Norfolk coast. The hospital is for adults who require assessment and treatment in a mental health inpatient setting. The provider is Southern Hill Limited.

The hospital has five acute wards – Cavell a 15 bedded ward (male), Lincoln a 13 bedded ward (female), Burton an 8 bedded ward (male), Pearson an 8 bedded ward (male) and Adler a 9 bedded ward (male), totalling 53 bedrooms. No wards provided mixed sex accommodation.

Southern Hill Hospital was registered by the Care Quality Commission in May 2018. The hospital is registered to carry out the following regulated activities:

- Assessment and treatment for persons detained under the Mental Health Act 1993
- Treatment of disease, disorder or injury
- Transport services, triage and medical advice provided remotely.

The hospital has a registered manager. The registered manager, along with the provider, are legally responsible and accountable for compliance of the Health and Social Care Act 2008 and associated regulations, including the Health and Social Care Act 2008 (Regulated Activities) 2014 and the Care Quality Commission (Registration) Regulations 2010.

On the day of inspection there were 35 male patients, of which 25 were detained and 10 were informal and 13 females of which nine were detained and four were informal.

How we carried out this inspection

We carried out an unannounced visit to Southern Hill Hospital on 12 January 2022 and carried out further remote interviews with staff on 13 and 14 January 2022.

We focused on key lines of enquiry within the safe, effective and well-led domains.

During the inspection we:

- visited three wards
- spoke with the registered manager
- spoke with the Chief Executive Officer
- spoke with three medical staff
- spoke with four nurses and support workers
- reviewed five patient records
- and reviewed a range of policies and procedures, data and documentation relating to the delivery of the service.
- spoke with nine patients and seven carers prior to the inspection visit.

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

What people who use the service say

Summary of this inspection

Most patients told us they were happy with the service in relation to the quality of care and treatment received and the majority of staff treated them with respect and kindness. However, two patients told us that agency staff were not as interested in the care of patients. Most patients felt involved in their care and treatment and there was good communication with the staff and doctors.

One patient told us the ward environment was not pleasant describing “stains in the toilet, curtains that looked old and furniture that had been vandalised and not repaired”.

Two carers told us they often had difficulty getting through to their relative via the main telephone line. One carer told us they had little communication with the medical or management staff and two carers told us they did not feel fully involved in their relatives’ care. However, the majority of carers told us staff were caring, helpful, committed and kind, although sometimes there was a shortage of staff resulting in activities being cancelled.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **MUST** take to improve:

- The service must ensure that the use of rapid tranquilisation is in line with the provider’s policy and follows the National Institute for Health and Care Excellence Guidance. Regulation 12 (2)(g)
- The service must ensure learning from incidents is fully embedded within all governance processes. Regulation 17(1)(2)(a)

Action the service **SHOULD** take to improve:

- The service should ensure all ward areas are in good decoration.
- The service should ensure that physical health assessments take place following admission and are recorded in line with the provider’s policy.
- The service should clearly display accessible information advising informal patients of their rights to leave the ward.

Our findings



Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Not inspected	Not inspected	Requires Improvement	Requires Improvement

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

Requires Improvement 

Safe	Requires Improvement 
Effective	Good 
Well-led	Requires Improvement 

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

Requires Improvement 

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

Safe and clean care environments

Safety of the ward layout

Staff completed risk assessments of ward areas and mitigated risks they identified. The wards were laid out, so staff had a good view of all communal areas. There were convex mirrors to mitigate blind spots.

The service complied with guidance on mixed sex accommodation.

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

Maintenance, cleanliness and infection control

We visited three wards. Most ward areas were clean, well-furnished and fit for purpose, However, there were some areas of the wards in need of repair or redecoration. For example, Burton ward had marks on the walls in the dining area and lounge and we saw broken glass panes in Cavell ward that had been covered with Perspex.

Mandatory training

Staff had completed and were kept up-to-date with their mandatory training. All compliance rates for mandatory training courses were above the hospital target of 85%. Identified staff had completed intermediate life support (ILS) at 92%.

Managers kept a record of training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments for each patient on admission and reviewed and updated these regularly, including after any incident.

Care records for patients had up-to-date risk assessments and staff met daily to discuss specific risks to each patient. Staff documented these discussions well.

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

Requires Improvement 

The multidisciplinary team were involved in completing patient risk assessments, so all aspects of care and treatment were considered.

Use of restrictive interventions

The service took part in the restraint reduction network and physical interventions were used as a last resort. Data analysed demonstrated the use of physical intervention remained consistently low due to the increased use of verbal de-escalation and the same techniques being consistently used by staff.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

The patient safety officer team provided regular and consistent support to staff on each ward to provide skilled and timely interventions to prevent escalation of incidents.

Staff were kept up-to-date with restraint training. On the day of inspection, 89% of eligible staff had completed PRICE (Protecting Rights in a Caring Environment) restraint training.

There was a lack of information for patients informing them of their rights displayed within the wards, however managers advised that patients are given a booklet on admission telling them about their rights.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. On the day of inspection, 93% of all staff had completed adult safeguarding training.

Two staff interviewed could give examples of how to protect patients from harassment and discrimination.

There were clear procedures to keep children visiting the ward safe and there was a designated visitor's room available.

Safeguarding concerns were discussed at daily meetings and actions were recorded on a safeguarding log until they had been completed. The safeguarding log was up-to-date and documented actions taken, but there were significant gaps in identifying lessons learnt from incidents.

Medication management

Staff did not always follow systems and processes when safely prescribing and recording medications. Audits identified that staff did not always follow the provider's policy and protocol for the use of rapid tranquilisation. The most recent monthly audit identified gaps where staff did not always complete patient records. For example, there were omissions in the prescribing doctor completing clinical entries and prescribing aftercare and staff did not always record physical health monitoring and observations following administration within patient notes. This meant it was not clear that checks had taken place. Whilst 95% of staff had completed rapid tranquilisation training, not all staff we spoke with were clear about the provider's guidelines for physical health monitoring following administration of rapid tranquilisation.

Reporting incidents and learning from when things go wrong

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

A total of 94% of staff had completed risk and incident management training.

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

Requires Improvement 

Managers debriefed and supported staff and patients after any serious incident.

Managers analysed data from incidents and found incidents increased at certain times. This meant they were able to make changes to the ward routine. There had been two incidents when the same patient had absconded via the perimeter fence in November 2021 within a four day period. Mitigation to ensure the safety of the patient was to review the risk assessment, increase observation levels and relocate the patient to an alternative ward. Staff also investigated a further absconding incident by another patient who left the ward via a fire door. Managers learnt the general alarm system had failed across the site. Following this incident, the general alarm systems were checked daily and the patient safety officers continued daily checks to the external fire doors.

We reviewed the provider's incidents tracker and quarterly report. Incidents were recorded and actions documented, however it was not clear from the documentation if lessons learnt from incidents had been considered or shared with the staff team as this had not been recorded. The registered manager also told us that lessons learnt were shared with staff during team meetings and supervision. We found this was not fully embedded on reviewing evidence from the provider. We are continuing to review an open incident following our inspection.

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

Good 

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

Assessment of needs and planning of care

We looked at five patient records which included care plans and risk assessments. Staff completed risk assessments for each patient on admission. Staff regularly reviewed and updated care plans when patients' needs changed. Care plans were personalised, holistic and included recovery plans.

It was not clear from records that all patients had a physical health assessment on admission and that their physical health was always regularly assessed during their time on the ward. Two of the five records reviewed did not indicate a physical health assessment had taken place and a further two records showed whilst a physical health assessment had been completed, it was unclear if this was at the point of admission. However, following the inspection the service provided evidence of a physical health check audit for 175 patients demonstrating the provider had followed its' own policy and NICE guidance.

Patients had access to a local GP.

Nursing staff completed general physical health observations and daily temperature checks were completed for patients due to the Covid-19 pandemic.

Skilled staff to deliver care

The service had access to a full range of specialists to meet the needs of the patients on the ward. The multi-disciplinary team consisted of doctors, nurses, occupational therapist and psychologist.

Managers gave each new member of staff a full induction to the service before they started work.

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

Requires Improvement 

Staff were supported to identify their training needs and managers gave them the time and opportunity to develop their skills and knowledge. For example, two staff told us they had recently completed training on supporting individuals with a personality disorder diagnosis.

Managers ensured staff attended regular team meetings and reflective practice sessions. Staff meetings took place weekly and were documented for staff to access if they could not attend. The documentation included incidents, observation levels, admissions, referrals, discharges and length of stay. Whilst incidents and operational concerns were raised and discussed there was little evidence of learning and action.

Multi-disciplinary and interagency teamwork

Staff from different disciplines including medical, nursing, occupational therapy and psychology worked together as a team to benefit patients.

Staff held regular multidisciplinary meetings and daily morning meetings to discuss patients and improve their care. Staff made sure they shared clear information about patients and any changes in their care, including daily meetings and recorded these discussions.

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

Requires Improvement 

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

We have rated this domain as requires improvement as we found regulatory breaches.

Leadership

The registered hospital manager had the skills, knowledge and experience to perform their role. They had a good understanding of the service they managed and were visible and approachable for patients and staff.

Culture

Prior to inspection a concern had been raised anonymously with CQC in relation to the behaviour of a senior member of the organisation. However, the organisation have advised they have investigated and are taking no further action.

Staff we spoke with during inspection told us they felt respected, supported and valued. However, prior to and following the inspection, we were notified of concerns from a variety of sources regarding the wellbeing of staff.

There were no bullying or harassment concerns at the time of inspection. As part of the inspection process Care Quality Commission liaised with other agencies to gather and review information pertaining to staffing concerns.

Managers ensured staff were kept up-to-date with equality and diversity training. At the time of inspection, 96% of staff had completed this.

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

Requires Improvement 

Governance

Management information was reviewed and regularly shared with senior management. The manager compiled monthly updates on key information that were shared with staff including; staffing, training, patient and quality updates.

Systems and processes were in place for medical governance including; appraisals, supervision and mandatory training. We saw evidence of the supervision and appraisal tracker and the training compliance report evidencing an overview of training completed and future training planned.

Clinical governance meetings took place monthly. Although there was a framework of what must be discussed and actions were identified, not all tasks were added to the action log. This meant that identified actions were not addressed at the next clinical governance meeting. For instance, we saw a theme in one meeting that had been identified as a concern but was not logged as an action. This theme then appeared again in a meeting two months later.

The human resource audit tracker enabled managers to maintain oversight and ensure all relevant checks had taken place. However, there was no evidence that disclosure and barring service (DBS) checks had been completed for all staff. Three out of four personnel records reviewed did not demonstrate DBS checks had been undertaken. However, following the inspection the provider supplied evidenced that these records related to overseas staff who were not yet eligible for a DBS but alternative appropriate checks were in place.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care.

Senior staff and managers met every morning to discuss ward issues including risks and review incident reports. Managers then added incidents and safeguarding concerns requiring investigation to an action log until the investigations had been completed.

The manager identified, collected and reviewed issues via a risk register. We saw evidence of a continuous improvement plan which highlighted risks and issues and identified actions to address these. For example, there was a clear process in place to address the hospitals response to COVID-19 pandemic.

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

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

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
The service did not ensure that the use of rapid tranquilisation was in line with the provider's policy and follows the National Institute for Health and Care Excellence Guidance.

Regulated activity

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

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance
The service did not ensure learning from incidents was fully embedded within all governance processes.