Partnerships in Care Limited

Priory Hospital East Midlands

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	Inadequate
Are services safe?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Priory Hospital East Midlands is in Annesley in Nottingham and is one of the hospitals of Partnerships in Care Limited. The provider offers a specialised assessment and treatment to help patients for return to either local services or alternative appropriate accommodation.

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

We inspected safe and well-led key questions for the service. We did not inspect the caring, effective and responsive domains. The domains of caring, effective and responsive are currently rated as Good and will not change following this inspection.

However, we rated the safe and well-led key questions as inadequate and so the service is now rated inadequate overall. We have placed the service in special measures.

Following the inspection, the provider was issued with a section 31 letter of intent. The letter of intent informs the provider of CQC intention to take urgent enforcement action if improvements highlighted are not made immediately. The provider responded to the concerns we raised and put in place measures to safeguard people who used the service.

The provider submitted an action plan which provided us with assurance that appropriate action is being and will continue to be taken.

In addition, we served the provider two warning notices which required them to make improvement to the management of ligature risk, the way observations are carried out, the safe disposal of medicines and clinical sharp waste, the appropriate monitoring of phycial health following the administration of rapid tranquilisation and making improvements required following our last inspection. The provider must have robust governance arrangements in place to manage risk effectively, to ensure there are always enough staff with the right skills and competence to meet patients needs and that all staff had the information they needed to understand what care they needed to deliver to patients and that they had robust systems in place to ensure that staff entering the building had their identitity check and had the right skills and experience to keep patients safe and meet their needs. The provider is required to ensure they make the required improvements by 29 August 2022.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service.

The service will be kept under review; if we have cause for concern we will not hesitate to inspect and take any appropriate action to ensure those using the service are safe and well cared for.

Our rating of this location went down. We rated it as inadequate because:

Summary of findings

- Some of the concerns raised at the previous inspection such as staff not following infection prevention and control procedures, wards being unclean and not fit for purpose, food not being labelled appropriately, patients' physical health monitoring not being carried out adequately after receiving rapid tranquillisation and the use of blanket restrictions had not been fully addressed.
- Since the last inspection in December 2021 there had been no progress in reducing restriction interventions within the service. We saw the restrictions on access to the garden on Barton ward was still in place.
- Staff had completed individual risk assessment for patients at risk of ligating however we were concerned that the toilets in ensuite bathrooms posed a ligature risk. The service had not reduced or removed all risks identified to keep patients safe, in particular the risk of patients having access to potential ligature anchor points in vacant unlocked bedrooms.
- The service did not act in a timely manner to resolve maintenance issues. On Littlemore ward we found a patient's shower was leaking into their bedroom.
- The service did not have enough staff who knew the patients and staff did not always receive basic information to keep patients safe. The service relied heavily on agency staff and there was high use of agency staff. Leaders did not have oversight of agency staff and there weren't the necessary checks in place in order to check identity of agency staff entering the building. The service did not always manage safe staffing well, not all shifts had an appropriate gender mix of staff.
- There had been no improvement to the way staff managed rapid tranquilisation since the last inspection in December 2021. Staff did not always follow the provider's use of rapid tranquilisation policy to ensure all patients received physical health checks following administration of rapid tranquilisation.
- Staff did not always follow the provider's infection, prevention and control (IPC) policy and did not always wear face masks correctly (as required during the pandemic) putting patients at risk of Covid 19.
- Some staff did not feel respected and valued by senior leaders.
- Staff did not always follow the provider's observation policy by observing patients in an appropriate and prescribed way in line with good practice.
- Handovers were completed, however not all risks and information were recorded and handed over in a timely manner. This meant that staff were not always aware of risks or key aspects of care for patients.
- The service did not have effective systems in place to manage contraband or restricted items by storing them in the correct way. This issue was raised at the inspection in December 2021.
- The service did not always manage medicines disposal safely.
- Managers did not always investigate complaints thoroughly. Managers failed to ensure all complaints had been fully recorded, investigated and changes made to practice to ensure they did not reoccur.

However,

- Incidents that were recorded were thoroughly investigated
- The patients we spoke with told us that staff were caring, approachable and respectful.

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	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Priory Hospital East Midlands

Priory Hospital East Midlands is in Annesley in Nottingham and is one of the hospitals of Partnerships in Care Limited.

Priory Hospital East Midlands is registered to provide the following regulated activities:

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

The provider offers specialised assessment and treatment to help patients for return to either local services or alternative appropriate accommodation. All bedrooms have private en-suite bathrooms. There is a secure garden for each ward and a gym which can be used with staff supervision.

The following service and wards were visited on this inspection:

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

- Littlemore Ward, a female psychiatric intensive care unit with ten beds.
- Barton Ward, an acute admission ward for females with nine beds.

The most recent focussed inspection of this location was in September 2021. The location was rated as requires improvement overall and inadequate in Safe.

What people who use the service say

We spoke with five patients during the inspection. Patients told us that staff were caring, approachable and respectful. One patient told us they felt staff acted in their best interest and was helping to support them closer to discharge. However, one patient on Littlemore ward told us they did not feel safe due to there not being enough staff available on the ward. One patient on Barton ward told us their dietary requirements were not being met.

How we carried out this inspection

The inspection team visited the wards on 30, 31 May, 1 June and completed further off-site inspection activity. During the inspection we:

- Visited the service and observed how staff cared for patients;
- Toured the wards and clinical environments;
- Spoke with five patients that were using the service;
- Interviewed 11 staff including two ward managers, two consultants, two nurses, two healthcare assistants, a bank healthcare assistant, and two agency healthcare assistants;
- Interviewed the Hospital Director;
- Interviewed the Managing Director;
- Attended a morning meeting;
- Reviewed three patient care records;
- Reviewed 14 medicine records;
- Reviewed policies and procedures relevant to the running of the service.

Summary of this inspection

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.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust 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 it keeps patients safe and must put in place effective systems to manage ligature risks (Regulation 12 (2) (a) (b) Safe care and treatment)
- The service should ensure that maintenance issues are resolved in a timely manner and that all areas are fit for purpose. (Regulation 15)
- The service must ensure that it keep patients safe by ensuring observations are carried out robustly in line with recognised good practice that should be reflected in the providers policy and procedure (Regulation 12 (2) (b) Safe care and treatment)
- The service must ensure the proper and safe management of medicines (Regulation 12 (1) (2) (g) Safe care and treatment)
- The service must ensure that the use of rapid tranquilisation is in line with the National Institute for Health and Care Excellence guidance (Regulation 12 (2) (g) Safe care and treatment)
- Managers must ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on all shifts. (Regulation 18 (1) (2) (a) Staffing)
- Managers must ensure that the risk register reflects all the current areas of risk and those risks are mitigated with appropriate action plan in place. (Regulation 17 (1) (2) (a) (b) Good Governance)
- The service must ensure that the gender mix of staff on shift allows for female staff to support with observation. Regulation 17 (1) (2) (a) (b) Good Governance)
- The service must ensure that it operates effective systems and processes to assess, monitor and improve it services to ensure it delivers safe and effective services at all times. (Regulation 17 (1) (2) (d) Good governance)
- The service must ensure that food is correctly labelled to prevent risk of infection of poisoning (Regulation 12 (2) (a) Safe care and treatment)

Action the service SHOULD take to improve:

- The service should ensure patients have safe storage for possessions (Regulation 10 (2) (a))

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	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

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

Inadequate

Safe	Inadequate
Well-led	Inadequate

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

Inadequate

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

Safe and clean care environments

Not all wards were safe, well maintained and fit for purpose. However, they were clean, well equipped and well furnished.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all ward areas. Staff knew about any potential ligature anchor points but did not always effectively mitigate the individual patient risks to keep patients safe. For example, on Barton ward there were toilet seats in six of the nine bedrooms that were a potential ligature point. Whilst they had been risk assessed, patient individual risk assessments were not completed and/or staff did not follow them. For example, in the risk assessment empty bedroom doors should be locked but on inspection we found bedroom doors to be open and patients were able to access. This was addressed by the provider during the inspection; the provider removed all the toilet seats. Following us issuing the letter of intent the provider reviewed all the individual risk assessments and replaced the toilet seats for those patients who did not have a risk related to the toilet seat.

Staff could observe patients in all parts of the wards. In areas of the ward where is difficult to observe patients there were convex mirrors to mitigate blind spots. Close circuit television cameras (CCTV) were in place throughout the wards, grounds and gardens.

The ward had ligature cutters available to staff in key areas of the ward to allow quick access in the event of a ligature incident.

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

Maintenance, cleanliness and infection control

Ward areas were clean, this had improved since our inspection in September 2021. However, not all areas were well maintained and fit for purpose. On Littlemore ward we observed that a patient's shower leaked into their bedroom and there were areas of the ward that needed repair and redecoration. On Littlemore ward there were marks on the ceiling in the communal area and damage to the floor. On Barton ward we observed gaps in sealant in bathrooms and heavily marked, slippery shower floors.

Staff made sure cleaning records were up to date. However, on both wards we found food in the fridges which were unlabelled so there was no way of knowing when it had been opened, when it should be consumed or when it was out of date. We were concerned that consumption of this food could pose a risk to patients. This issue was raised last inspection in September 2021.

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

Inadequate

Staff did not always adhere to the infection control procedures or follow the provider's infection control policy. We observed on CCTV footage night staff did not always wear face masks correctly (as required during the pandemic) potentially putting patients at an increased risk of COVID-19. Staff had access to hand sanitiser and hand washing facilities. In response, the provider has reminded staff to adhere to infection control procedures and were starting to undertake weekly audits to ensure compliance.

When reviewing training compliance, we found 90% of staff had completed training in infection control.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. During our inspection the clock was showing the wrong time, this was addressed by staff during the inspection. The seclusion room was clean which was an improvement from our previous inspection.

There were no patients in the seclusion room at the time of inspection.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly and were in date.

However, on Barton ward we found that not all risks had been addressed. We found the sharps bin which was located in an unlocked cupboard and did not have a secure tag, as well as an overflowing disposal of medicines bin. These issues were highlighted to the provider during the inspection and were resolved.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients. Staff received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe.

We found that not all shifts had a balanced mix of female and male staff on shift to meet the needs of the patients.

The vacancy rate reported for qualified nursing staff across both wards was 56%. The vacancy rate for health care assistants across both wards was 77%.

The service had high usage rates of bank and agency staff; managers requested staff familiar with the service. One member of staff told us that agency use was very high and some shifts had only two members of substantive staff for the whole hospital. We reviewed rotas and found on 19 May 2022 there was one substantive member of staff and five bank or agency staff on Barton ward and two substantive staff and eleven on Littlemore ward. At the time of inspection, the service had three bank nurses, 55 bank health care assistants and one locum nurse.

Managers did not make sure all bank and agency staff had a full induction and understood the service before starting their shift. We spoke with an agency staff member who told us their induction consisted of a walk around the ward and an introduction to patients. We reviewed rotas from 19 May to 30 May 2022 and it was unclear which agency members of

staff had attended each shift. Managers were not able to identify agency members arriving for shift and identification was not always checked. At inspection we observed staff arriving for the early shift and found that agency staff checks were not always followed. This meant that an agency nurse was sent to a ward without the necessary checks that ensured they were approved by the agency.

The service had an average turnover rate of 7% for the previous 12 months. The turnover levels were reducing.

Managers supported staff who needed time off for ill health. Levels of sickness were on average 7% for the previous 12 months.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers reviewed shift requirements for the days ahead in the daily morning meetings. Although they used high levels of bank and agency to meet the required number of staff.

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

The ward manager told us that patients had one to one sessions with their named nurse when they were available. One patient on Littlemore ward told us that there weren't always enough nurses available for patients.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff did not always share key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover as well as two duty doctors available to get to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Staff compliance with mandatory training sessions for permanent staff was 89%. However, managers did not hold up to date profiles of agency and bank staff training. The service did not hold profiles of agency staff including their DBS, skills and qualifications. Managers told us that the agency kept these records. We were concerned that managers did not have oversight of these records to assure themselves that agency staff were appropriately trained to provide safe care and treatment to patients.

The mandatory training programme was comprehensive and met the needs of patients and staff. Staff had access to additional training via an online platform.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers used an electronic dashboard system to monitor staff compliance with training.

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

Inadequate

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well and follow best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

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

Management of patient risk

The multidisciplinary team met daily to discuss each patients' risk this information was recorded and passed to the relevant ward. We found that printed notes, for agency staff to use were not always up to date with patients' current needs and risks.

Staff did not always know about all risks to each patient in order to prevent or reduce risks. Information regarding potential risks was not always handed over in a timely manner. This meant that staff coming on to shift were not always aware of previous incidents and risks. We found handover documents did not always contain information relating to incidents on previous shifts. For example, we reviewed handover notes and found there had been an incident on 27 May 2022 which was not documented and handed over to staff arriving for shift 28 May 2022.

Staff did not always follow the provider's policy and procedure when completing observations. During our review of CCTV, we observed on Littlemore ward a member of staff entering a patient's bedroom for a prolonged period of time. This was investigated by the provider during the inspection and there was no related incidents or harm to patients. We found during our review of CCTV two staff members completing observations sat in a position which could lead to falling asleep.

Staff did not always follow the provider's policy when they needed to search patients or their bedrooms to keep them safe from harm. During our ward tour of Littlemore ward, a patient presented a contraband item to inspectors which they kept in their bathroom.

Use of restrictive interventions

The service monitored and reported on the use of restrictive interventions. Managers reported that the levels of restrictive interventions were reducing. However, during the inspection staff told us they did not routinely report all incidents that took place. So, whilst managers were reviewing incident that had been reported on a daily basis by senior managers, they did not review all incidents. Therefore, we were not assured that the data was accurate and levels were reducing.

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.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

There had been 115 incidents of rapid tranquilisation from 1 March to 30 April 2022. Staff did not always follow National Institute for Health and Care Excellence guidance when using rapid tranquilisation. We found two examples of patient's

records that did not document monitoring of the patient's physical health in line with guidance, managers and clinicians reported to us that monitoring was not always completed. This was in relation to patients' refusing to have physical health observations taken however, observations could have taken place and recorded including monitoring of respiration.

When a patient was placed in seclusion, staff kept clear records. However, we found that best practice guidelines were not always followed. We reviewed one seclusion record which identified concerns regarding restricted items being taken into the seclusion room.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse however not all staff knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. We spoke to 11 members of staff were able to tell us what abuse was, how to recognise and knew how to report.

Staff kept up to date with their safeguarding training. At the time of inspection, 87% of all regular staff had completed adult safeguarding training. The provider did not have records of agency staff completing adult safeguard training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. Staff told us that they booked visiting rooms for patients and people under 18 years old to promote family contact and keep the young people safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had access to a safeguarding flow chart which highlighted what action they needed to take and who contact if a referral needed to be made.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff did not always have easy access to clinical information. It was not always easy for them to maintain high quality clinical records –paper-based and electronic.

We looked at three patient records, they were electronic format and were comprehensive. All regular members of staff had easy access to the records. However, managers had not ensured that a that agency staff had access to the electronic record. Therefore, they relied on printed copies of patients' clinical information. During this inspection we noted that the printed information was not up to date.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

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

Inadequate

Medicines management

The service used systems and processes to safely prescribe, administer, and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. However, medicine records were not always complete. For example, on Littlemore ward patients' profile had not always been completed, one patients file did not have a completed consent form, allergies were not always recorded, and rapid tranquillisation observation charts had not been completed in full.

The pharmacist completed weekly audits on medications and ensured that staff knew about safety alerts and incidents, patients received their medication safely. However, they did not address the issues we found during inspection.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Medicines were reviewed weekly during ward rounds.

Staff generally stored and managed all medicines and prescribing documents safely. However, we found on Barton ward medicine disposal was not always managed well. We found the sharps bin located in an unlocked cupboard and did not have a secure tag, as well as an overflowing disposal of medicines bin.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Social Care Excellence guidance.

Track record on safety

The service did not have a good track record on safety.

From 1 February to 30 April 2022 there had been 478 incidents on Littlemore and 229 incidents on Barton Ward. The incidents recorded mainly related to restraints that had taken place.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. However, managers investigated incidents that had been reported and shared lessons learned with the whole team and the wider service.

Staff did not always know what incidents to report and how to report them. One agency member of staff we spoke to did not know how to report incidents that included understanding of the datix system. This meant that incidents may not be recorded accurately.

Staff did not always raise concerns and report incidents and near misses in line with provider policy. Not all staff had access to the system which meant that we could not be assured that all incidents and near misses had been recorded.

The service had no never events on any wards.

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

Inadequate

Staff understood the duty of candour. They knew the process for duty of candour that meant they needed to be open and transparent and provide patients and families a full explanation if and when things went wrong. However, due to the concerns we found regarding incident reporting we were not assured that duty of candour was followed.

Managers debriefed and supported staff after any serious incident. Managers had recently introduced well-being leads on both wards who staff could talk to if they needed to.

Managers investigated incidents that had been reported thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received emails with lessons learnt from all the providers locations. A bulletin is printed and displayed on each ward which provides information about lessons learnt from other hospitals.

Staff told us they did not meet to discuss the feedback and look at improvements to patient care. Two members of staff told us they have raised feedback with managers, but they have not been acted on by managers.

There was evidence that changes had been made as a result of feedback. There had been an incident on Barton ward where managers evidenced that further environmental checks had been put in place following an investigation.

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

Inadequate

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

Leadership

Managers had not addressed all the concerns raised from the previous inspection. Managers had failed to improve staffs adherence to infection, prevention and control procedures in relation to wearing personal protective equipment correctly. Food was not labelled correctly when stored in fridge's this was not in line with guidance, staff were not routinely monitoring patients physical health after administering rapid tranquilisation. Wards remained not fit for purpose. Although we did find they had made progress in the following area, cleanliness of the hospital and wards. Managers now needed to ensure changes are sustained and embedded in to practice.

Since the last inspection there had been a recent change in the management. The hospital director/registered manager had been in place since March 2022. They had worked hard to make improvements within the service but at the time of this inspection they had not yet been fully embedded.

The new registered manager and new director of clinical services had the skills, knowledge and experience to perform their roles. They had an understanding of the services they managed and the challenges they faced. However, there was a need for clear support and oversight from the senior leadership at the Priory.

Staff and patients told us that leaders were visible in the service and approachable for patients and staff.

Managers provided clinical leadership training for qualified nurses, we were told by managers that development opportunities were available through inhouse and external training.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. Values included putting people first, being supportive, acting with integrity, striving for excellence and being positive.

The vision and values were displayed around the hospital and managers told us they were an agenda item on supervision and appraisal documentation.

Managers clearly stated the purpose of the service and communicated that successfully to staff and stakeholders. All staff had a job description and staff understood the purpose of their roles and the purpose of the service.

Culture

Staff did not always feel respected, supported and valued. Managers said the provider provided opportunities for development and career progression. Not all staff said they could raise any concerns without fear.

Two members staff told us they did not always feel valued; there had been incidents of bullying on the wards that proceeded the current changes of managers at the hospital. Staff reported they felt stressed and received little support from senior leaders up to and including the time of our inspection.

Managers had not ensured that staff had access to regular supervision or an annual appraisal. Staff working at the hospital told us there were high levels of stress and that they had not received regular supervision or an annual appraisal. We reviewed supervision records and found that since January 2022 the provider had achieved the target supervision rate once and 81% of appraisals were in progress.

Staff also told us that the service struggled to retain staff and there was little in place for incentivising staff to stay. This meant there was high agency use, staff told us that some shifts had over 50% agency staff. The newly appointed director had developed an action plan to address this issue. As a result, they had put in place a wellbeing champions for staff to talk to. The action plan was discussed at clinical governance meetings and included dated deadlines for actions to be taken. There was evidence that actions were taking place and being progressed.

Staff performance issues were addressed in line with organisational policy. During the inspection we were made aware of performance issues and how these were being managed by senior leaders in line with policy.

Managers told us staff had access to whistleblowing policies and could escalate concerns through line management. Staff varied in their responses around whether they felt able to raise concerns and did not feel these were kept anonymous.

Staff knew who senior managers were and told us they were able to communicate with them, however staff told us they did not feel that issues highlighted to senior managers were acted upon.

Managers told us of development and career progression prospects available for staff and managers were available through in-house training opportunities.

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

Inadequate

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

The service held monthly clinical governance meetings; these meetings were well attended by senior leaders. Clinical governance meetings addressed concerns identified however we found that not all actions marked as complete had been completed. For example, 'You said we did boards' were marked as a completed action however whilst the boards had been delivered, they had not been put up on the wards.

Some of the concerns raised at the previous inspection such as staff following infection prevention and control procedures, wards being fit for purpose, food labelling, patients' physical health monitoring after receiving rapid tranquillisation and the use of blanket restrictions had not been fully addressed.

Managers failed to ensure that they met the set planned staffing levels for the wards, to keep patients safe. They reviewed staffing numbers in daily morning meetings and then regularly reallocated to other wards to cover their unfilled shifts.

Managers made immediate arrangements to cover vacant posts. Although we found that vacant posts were covered by locum or agency staff.

Mangers had access to data that was not accurate. We reviewed rotas where we found that named agency staff members on the rota were not always the member of agency staff who arrived to complete the shift. We found there was a WhatsApp group where agency staff members would swap shifts amongst themselves resulting in managers not knowing what members of agency staff would be arriving at the hospital for shift. The rotas we reviewed did not list job roles of the staff or agency staff on each shift. The service did not hold up to date profiles of agency staff including their DBS, skills and qualifications.

Managers did not always investigate complaints thoroughly. Managers failed to ensure all complaints had been fully recorded, investigated and changes made to practice to ensure they did not reoccur. During our inspection, one patient had made a verbal safeguarding complaint to senior management which was not followed up. We were not assured the incident or patient complaint had been investigated.

During our inspection, we escalated urgent and significant concerns with regards to observations, staffing and rotas, PPE compliance and ligature risks. These concerns were escalated to the provider who responded with an action plan, evidence, and assurances that immediate actions had been taken to mitigate the risks.

Management of risk, issues and performance

Managers did not ensure that all staff including agency staff had access to the information they needed to provide safe and effective care. Agency staff were not able to access patients' records, printed notes were not always up to date with patients' current needs and risks.

Senior leaders were not aware of all the concerns we raised at this inspection. This included the lack of oversight of agency staff entering the building, physical health monitoring, ligature risks and handover documents. This meant we were not assured that patients were safe at the time of this inspection.

The provider had a risk register in place which they used to record, review and manage risk to the service. However, this did not address all of the concerns we identified at inspection.

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

Inadequate

Information management

Staff collected analysed data about outcomes and performance that were recorded however did not engage actively in local and national quality improvement activities.

The provider had an internal inspection in April 2022 completed by an NHS Trust that commission beds within the service. Managers were in the process of developing monthly and annual audit programme for the purposes of learning and development.

Engagement

Managers engaged actively with local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Senior managers had regular meetings with local adult mental health services including quarterly quality reviews.

Learning, continuous improvement and innovation

The hospital did not participate in any accreditation schemes at the time of inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The service did not ensure that maintenance issues were resolved in a timely manner.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service did not ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff on shift.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not have effective systems in place to manage ligature risks. The service did not ensure observations were carried out robustly in line with recognised good practice. The service did not manage the disposal of medicines safely. The service did not ensure that the use of rapid transquilisation was carried out in line with National Institute for Health and Care Excellence guidance. The service did not ensure that food was labelled and stored correctly.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not ensure the risk register reflected all the current areas of risk. The service did not ensure that the gender mix of staff on shift allowed for female staff to support with observation. The service did not have effective systems in place to assess, monitor and improve its services to ensure it delivered safe and effective services.