Safety

Key points:

- Management and auditing of medicines at Rampton Hospital had improved since our last visit. However, we were concerned that staff were not always following the correct procedure for prescribing and administering patients' medicines, which could constitute an assault and trespass against the person.
- The monitoring of high dose antipsychotic therapy was poor and potentially exposed patients to risk of harm.
- While the monitoring of patients' physical health following rapid tranquilisations had improved, we were concerned about the amount of rapid tranquilisations that appeared to be in use as well as the accuracy of recording.
- While we observed staff providing person-centred care, we remain concerned that people in long-term segregation were not always treated with dignity, compassion, and respect.

Medicines management

In previous inspections, we raised concerns about poor medicines management at Rampton. However, at our inspection in February we saw evidence of improvement. This included an excellent example of patient involvement. In this case, staff discussed the rationale for the patient's treatment, the benefits and side effects, likelihood of success, alternatives and the consequences of not continuing treatment. The patient was also offered leaflets about the medicine to help them make an informed decision.

We found that staff reviewed patients' medicines regularly as part of the multidisciplinary meeting and provided specific advice to patients and carers about their medicines, in easy read format if required. There was a system in place to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Decision-making processes were in place to ensure patients' behaviour was not controlled by excessive and inappropriate use of medicines. Staff were aware of STOMP (Stopping over medication of people with a learning disability or autism or both) and followed the principles.

When patients detained under the Mental Health Act (MHA) 1983 are prescribed medicines, they must have a completed T2 or T3 form. A T2 form is a certificate of consent to treatment under Section 58(3)(a) of the MHA. A T3 form is a certificate of second opinion under Section 58(3)(b) of the MHA for patients where the patient is not capable of understanding the nature, purpose and likely effects of the treatment, or where the patient is capable of understanding but does not consent to the treatment.

All medicines prescribed for patients who have consented or are not able to consent to the treatment must be written on the T2/T3 forms, including:

- the class of drug as indicated in the British National Formulary
- the number of medicines prescribed in each class and whether any medicines are excluded
- the maximum dosage
- how the medicine will be administered.

The forms must be attached to the medication chart. Only medicines listed on the T2/T3 form can be prescribed and administered to the patient.

Since our last visit, the trust had introduced a new, electronic system for auditing patients' medicines, which replaced the previous paper-based medication audit. T2 and T3 forms were checked as part of this process. Local managers were accountable for the audits and were expected to take action to address any issues identified. Audits were overseen by the local quality and risk meetings, and then escalated to the overarching forensic quality oversight group, which is chaired by the associate director.

Despite these improvements, patients told us that they had experienced:

- medication errors, especially regarding anti-psychotic drugs
- issues with administering medication
- being given the wrong medication
- being refused their PRN (pro re nata) or 'when required' medication
- not being given any medication at all.

Other issues we found in a very small number of cases included:

- consent to treatment (T2) forms not accurately reflecting the medicine being prescribed and administered
- current consent to treatment (T2) paperwork not being kept with the medication charts
- lack of evidence to show that the responsible clinician had discussed treatments with the patient.

We also found issues relating to high dose antipsychotic therapy (HDAT). This is defined by the Royal College of Psychiatrists as either a total daily dose of a single antipsychotic which exceeds the upper limit stated in the British National Formulary (BNF), or a total daily dose of 2 or more antipsychotics which exceeds the BNF maximum calculated by percentage. The doctor prescribing HDAT should clearly record the rationale for its use, and that the risks and benefits have been discussed with the patient. Using HDAT increases the risk of physical health complications and the patient requires regular monitoring.

A HDAT audit completed at Rampton Hospital in June 2023 found that 20% of inpatients were not receiving an annual review of their treatment, which was significantly higher than the national average. This audit also highlighted poor performance in monitoring of physical health.

During our review in February 2024, we found concerns with the monitoring of patients on HDAT. Staff had not recorded monitoring of 2 patients on HDAT on the appropriate form to ensure the correct physical monitoring had taken place. The rationale for continuing with HDAT prescribing was not always recorded as part of the multidisciplinary team review. Records of physical monitoring were stored on a separate electronic system that ward nursing staff did not have access to.

Previously, we have also raised concerns about the inconsistent monitoring of patients' physical health following rapid tranquilisation. Our review shows that this has improved since the inspection in 2022.

Rapid tranquilisation is oral medication or intramuscular injections that are used to calm or lightly sedate a patient to reduce the risk to themselves and/or others, and reduce agitation and aggression in the optimal way. The National Institute for Health and Care Excellence guidance on Violence and aggression: short-term management in mental health, health and community settings states that people given rapid tranquilisation need to be monitored at least every hour until there are no further concerns about their physical health. If the patient is in seclusion, then additional monitoring may be needed to ensure safety. The monitoring includes looking for side effects, vital signs hydration levels and levels of consciousness.

Between July 2023 to December 2023, there were 171 occasions where rapid tranquilisation was administered to patients. Staff had monitored the physical health of patients on 161 occasions. However, this meant that 10 people did not receive the monitoring needed to keep them safe.

Due to the way in which the data is recorded in the other 2 high secure hospitals we were not able to compare the use of rapid tranquilisation at Rampton Hospital with the other hospitals. However, we remain concerned about how much this is being used at Rampton Hospital.

The trust provided training for staff in rapid tranquilisation and had set a performance indicator of 85% of staff to be trained. At the time of our review, 73% of staff had completed the training, with only 8 out of 25 wards achieving or exceeding the target.

Nursing observations

To ensure patient safety and promote therapeutic engagement, mental health nursing staff carry out routine observations of patients. In previous inspections in September 2022, and June and July 2023, we raised concerns that nursing observations at Rampton Hospital were not being carried out in line with patients' needs, care plans or the hospital's policy. In some cases, patients were put on timed observations, for example, every 30 minutes, to ensure they were safe. This meant that staff had to observe the patients at the interval specified in their care plans and record what they observed. However, in one example, we found that a patient who needed to be observed every 30 minutes had been given a razor and then observations were not carried out as required in the care plan.

Since our previous inspections, nursing observations had improved. This included, for example, the introduction of CCTV reviews alongside nursing observations in January 2024. The reviews were introduced following incidents of records being falsified in different parts of the trust outside of Rampton Hospital (as reported in our section on managing risk at NHFT), and aim to assure leaders that observations are being carried out as per the trust's policy.

During this review we did not identify any issues of note in relation to nursing observations. Staff carried out observations in line with the hospital's policy and recorded them on electronic tablets. While we noted some late recording of observations, this was minimal and appeared to be caused by external factors, such as IT connectivity and equipment. For example, during October and November, we found evidence that IT connectivity issues at Rampton had led to an increase in the number of observations recorded as late.

Staff told us they liked using the tablets, but that there was small window of opportunity to record the observations before they were flagged as late. For example, we heard that if a nurse carried out an observation and then supported the patient before recording the observation, this would be marked as late. We are concerned that the time specified in the hospital's policy for late entries is too restrictive.

On previous inspections, we found that monitoring of observations was carried out at ward level without oversight from the hospital's leadership team. This would result in variable oversight across the hospital. Since our last inspections, the leadership team at the hospital is sent a daily monitoring report on observations. This data supports Rampton's quality matrons to identify and address hot spot areas, as well as support staff to improve practice. It also ensures patients are being observed and supported in line with their needs.

Restrictive interventions

Restrictive interventions including restraint, seclusion and long-term segregation, can have a devastating impact on people and cause them trauma. Since our report Out of Sight — Who Cares?, we've repeatedly called for providers to act immediately to reduce the use of restrictive practice, and to ensure they provide person-centred, trauma-informed care at all times.

In August 2023, we published our policy position on the use of restrictive practice. This recognises that the use of restrictive practices may be appropriate in limited, legally justified, and ethically sound circumstances in line with people's human rights. However, it is also clear that wherever restraint, seclusion or segregation is perceived to be the only safe option, providers must consider whether services provided meet the needs of the individual and are preventative in their approach to stop situations reaching crisis point.

On our previous inspections at Rampton Hospital we found elevated levels of restrictive practice that were not reviewed or recorded in line with the Mental Health Act (MHA) Code of Practice. This included individual care plans for patients when restrictive interventions had been used in risk management. While we have seen improvements in the use of restrictive interventions, there are still areas for concern.

Data from the Mental Health Services Data Set (MHSDS) restrictive interventions dashboard shows that between February and October 2023 there was a high rate of restrictive interventions at Rampton Hospital (ranging from 38 to 51 per 1,000 occupied bed days), when compared to the other 2 high secure hospitals. High rates may suggest that restrictive interventions are being used excessively. This may be due to a variety of reasons including, but not limited to, being understaffed and lack of de-escalation training for staff. However, it is important to note that high rates of reporting could also reflect accurate and successful recording of restrictive interventions. Between February 2023 and October 2023, the number of restrictive interventions for Rampton Hospital were consistently above 400 per month, rising to 570 per month in the latest data set. This was higher than the other trusts operating high secure units.

Data from the trust shows that from July 2023 to December 2023 there were 581 incidents of seclusion. Seclusion is defined in the MHA Code of Practice as, 'the supervised confinement and isolation of a patient, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of containment of severe behavioural disturbance which is likely to cause harm to others.' Of the 581 incidents, 154 had been reviewed. The trust found that 148 of the seclusions were in line with the MHA Code of Practice. However, 6 were not and the trust investigated these further. The trust took action in all 6 investigations, including staff conduct investigation, reporting a staff member to the police, reflective practice and discussion with staff in supervision.

Through our review, we saw evidence that staff at Rampton Hospital are attempting to get more patients out of long-term segregation. Long-term segregation is defined in the MHA Code of Practice as a situation where, in order to reduce a sustained risk of harm posed by the patient or others, which is a constant feature of their presentation, a multidisciplinary review and the commission authority determine that a patient should not be allowed to freely mix with other patients on the ward on a long-term basis.

Although it is currently lawful to isolate people for prolonged periods, if this is the least restrictive way of keeping them safe, long-term segregation has real implications for people's human rights and long-term psychological wellbeing.

Between October 2023 and December 2023, the overall number of patients in long-term segregation reduced from 48 to 41. While this is a positive step forward, we are concerned that patients still in long-term segregation are not supported to access fresh air or reintegrate back in the ward safely. As highlighted in our 2022/23 MHA annual report, access to fresh air and leave are important for people's recovery, and decisions around people's ability to take leave should be based on risk.

In our 2020 report Out of Sight: Who cares? we reported how prolonged isolation in artificial environments can be detrimental to people's health and recovery and lead to issues such as:

- people sleeping too much and getting into unhelpful sleeping patterns, which affects their opportunities to access therapeutic interventions
- people's physical health deteriorating, such as a decrease in mobility.

Our report also showed that for some people, as they get used to being away from others, their comfort zone can shrink and it can become harder for them to be able to integrate with others because of the loss of social skills.

In December 2023, 18 patients of 41 did not have access to leave their rooms. While reasons for patients not being allowed to leave their rooms were usually recorded, no rationale was given for 3 patients. In addition we found no oversight or monitoring of the reasons why patients were not allowed out of their room while on long-term segregation.