The Priory Hospital Chelmsford

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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.

Summary of findings

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 rated the Priory Hospital Chelmsford as requires improvement because:

- The provider had completed ligature risk assessments for each room, which were rated, and in date. However, staff did not record items including soap and towel dispensers in one room as present. The provider did not identify other items including hangers in wardrobes, garden furniture, trees and some door closers on the ligature risk assessment or rated these as a low risk. Staff did not identify ligature points in "safer rooms" on some wards. The shower curtains were collapsible at a weight of 40-45kg. However, some patients on Springfield ward were of a lower weight than this making this a potential ligature point. The provider managed the risks from ligatures by individual risk assessments and staff observations of patients
- One patient in receipt of the addiction therapy programme and detoxification did not have a record of their dependency levels by drug testing prior to administration of treatment and to therefore, guide prescriptions for detoxification. Two records for patients receiving detoxification did not include all required assessment information to guide withdrawal management for individual patients and patients receiving detoxification treatment.
- The provider did not have a specialist consultant for the addictions treatment programme at the hospital. Training, specifically in addictions, was minimal and staff received training in addictions at induction only.
- Chelmer and Springfield ward had out of date bandages and defibrillator pads which would be required in an emergency. However, these were replaced on the second day of our inspection.
- The provider complied with same sex accommodation where patients' male and female sleeping areas were segregated. However, male visitors entered the female corridor to visit female patients. When staff required bedroom doors to remain open, due to high levels of observations, male visitors would be able to see female patients in their bedrooms. This was a breach of the privacy and dignity of those patients.
- Chelmer ward, Springfield ward, the adolescent ward and the Lodge had blind spots where staff could not easily observe patients. However, this was mitigated by staff completing individualised risk assessments and observations.
- Staff left the doors separating Springfield ward from Chelmer ward open. It was unclear where each ward ended.
- Springfield ward rotas indicated the ward was understaffed on five occasions between November 2016 and December 2016. When we raised this with the ward manager, we were told that staff had probably been moved to other wards. However, we were unable to find a record of this on the rota.
- Records for Chelmer ward, Springfield ward and the Lodge showed risk assessments completed and updated, however, records were inconsistent between paper and electronic forms. Patient admission checklists on Chelmer ward were not always signed by staff as completed.
- Staff completed records of incidents of restraint. However, we did not always find accurate detail of staff involvement. The provider would not have access to accurate information should an incident require further investigation.
- Young people had safes in their bedrooms. However, these were not used to store young people's personal possessions, but used by staff to store restricted items.

However:

- Wards had clinic rooms which were well equipped with emergency medication present.

Summary of findings

- The provider was clean and had a homely feel. Staff completed risk assessments and fire safety checks. Staff dealt with maintenance issues in a timely manner.
- The provider reviewed serious incidents and made improvements to reduce the incidents such as additional training and improvements to the security and environment of the building.
- Staff completed assessments of patient needs on admission and physical health assessments with on-going monitoring of physical health problems. Patient care records mostly contained up to date, personalised and holistic care plans, which staff reviewed regularly.
- Psychological therapies were available to patients and patients undergoing the addictions programme completed the 12-step programme.
- Patients with eating disorders received treatment in accordance with the provider policy and the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) national guidance (Royal College of Psychiatrists, 2014).
- There was an effective system in place for checking Mental Health Act (MHA) documentation and staff had a good understanding of the MHA and the Code of Practice. Staff read patients their rights regularly. Staff had training in the Mental Capacity Act, 2005 (MCA) and generally demonstrated a good understanding of the MCA. No patients were subject to a Deprivation of Liberty Safeguards application during our inspection.
- Patients generally held positive views about the staff at the provider stating that staff were caring and attentive to their needs. Although patients on the adolescent ward said they felt unsafe due to recent incidents of absconsions from fire exits and verbal and physical aggression towards staff. The provider had taken action to address these incidents and to ensure the safety of young people.
- Patients with an eating disorder used an additional therapy room to eat their meals in private and young people had their own dining area for meal times.
- Systems were in place for managing and dealing with complaints with information provided to staff and patients. The provider shared learning from complaints with the staff team.
- The provider had good governance systems in place with dashboards to monitor quality objectives, a monthly learning outcome meeting and daily 'flash meetings' to review incidents and staffing issues. Staff had regular supervision and yearly appraisals.

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 	The acute ward included Chelmer ward a 16 bedded mixed sex ward providing in-patient beds for mental health assessment and treatment for patients with psychiatric needs and specialised assessment and treatment for addictions including drug and alcohol dependency. Springfield ward included a 12 bedded mixed sex ward providing assessment and treatment for patients with an eating disorders. The hospital also included "The Lodge" a three bedded mixed sex accommodation for patients receiving the addictions therapy programme.
Child and adolescent mental health wards	Requires improvement 	The child and adolescent ward included a 17 bedded mixed sex ward providing assessment and treatment for children and adolescents with mental health needs.

Summary of findings

Contents

Requires improvement

Priory Hospital Chelmsford

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; child and adolescent mental health wards; specialist eating disorders services and substance misuse/detoxification.

Summary of this inspection

Background to The Priory Hospital Chelmsford

Priory Healthcare Limited is the registered provider for Priory Hospital Chelmsford an independent mental health hospital providing 49 beds. The services at the Priory Hospital Chelmsford include:

- Chelmer ward: a 16 bedded mixed sex acute ward providing in-patient beds for mental health assessment and treatment for patients with psychiatric needs and specialised assessment and treatment for addictions including drug and alcohol dependency.
- Springfield ward: a 12 bedded mixed sex ward providing assessment and treatment for patients with an eating disorder. There was one male patient present at the time of our inspection but the provider planned to make this a female only ward in January 2017.
- Adolescent ward: a 17 bedded mixed sex ward providing assessment and treatment for children and adolescents with mental health needs.
- The Lodge: three bedded mixed sex accommodation for patients receiving the addictions therapy programme.
- The provider also provides mental health assessment and treatment on an out-patient and day patient basis. We did not inspect these services.

The Care Quality Commission registered The Priory Hospital Chelmsford to carry out the following regulated and activities:

- Treatment of disease, disorder or injury
- Accommodation for persons who require treatment for substance misuse
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures.

The service has a registered manager and a controlled drugs accountable officer.

There have been four inspections carried out at The Priory Hospital Chelmsford. The latest inspection was carried out on 2-3 March 2016 and published on 17 August 2016. The hospital were required to address the following issues including female patients not being observed by male patients when on observations, female young people having a female lounge, patients having access to a communal space and patients with an eating disorder were not eating meals in corridors, young people not going to another ward to access the clinic room and risk assessments being completed to enable staff to care for patients safely. The provider addressed all issues and is now compliant with all actions.

Our inspection team

Our inspection team was led by:

Team leader: Karen Holland, inspection manager, mental health hospitals.

Lead inspector: Neşe Marshall, inspector, mental health hospitals.

The team that inspected the service included two CQC inspectors, two inspection managers, a specialist advisor and an expert by experience who had experience of using similar services.

Why we carried out this inspection

We inspected this location as part of our ongoing comprehensive mental health inspection programme.

Summary of this inspection

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited all three wards and the Lodge, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 20 patients who were using the service
- spoke with five relatives of patients
- spoke with the registered manager, clinical service managers and ward managers for each of the wards
- spoke with 20 other staff members; including doctors, nurses, occupational therapist, psychologists, therapists, administrative staff, housekeeping staff and mental health administrators
- spoke with an independent advocate
- attended and observed a multi-disciplinary meeting
- collected feedback from 16 patients using comment cards
- looked at 23 care and treatment records of patients
- carried out a specific check of the clinic room and medication management
- looked at 44 medication prescribing charts
- looked at a range of policies, procedures and other documents relating to the running of the service
- looked at 12 staff personnel files.

What people who use the service say

We spoke to 20 patients on Chelmer and Springfield wards who generally held positive views about the staff at the hospital stating that staff were caring and attentive to their needs, and there was enough staff. However, some patients on Springfield ward said there could be more activities and a gym for patients to use.

We spoke to six young people who said they felt unsafe on the ward. Young people felt that staff ignored them, were not helpful or compassionate when people were self-harming and they received more information from other young people rather than staff. There had recently been several difficult incidents on the adolescent ward including young people absconding from fire exits and aggression towards staff. Young people referred to these incidents and felt these were causing them additional distress.

We spoke with two parents of young people. One parent said their child was safe on the ward and there was enough staff except in the evenings. Parents said the environment was clean. However, one parent referred to a recent incident at night involving the absconsion of young people and verbal and physical aggression towards staff. The provider had taken steps to manage the situation and make the ward safe.

Overall, we spoke to five carers who stated that the majority of staff were kind and caring.

Patients completed 16 comment cards, which were generally positive about the staff and the provider, with eight patients stating they felt safe and the staff were caring.

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?

Requires improvement

We rated safe as requires improvement because:

- The provider had ligature points not identified in one bedroom on their ligature risk assessment including towel and soap dispensers. Wardrobes had grooves in them where hangers were placed making them weight bearing. The provider had not identified these as a risk on the ligature assessment. Door handles were identified by CQC staff as ligature points but the provider took action to remove these during our visit. The provider had door closers in several places which staff recorded as not present on the ligature audit or rated these as a low risk. Ligature points were found in rooms considered “safer” by the provider. The garden was not included on the ligature risk assessment on the adolescent ward. The shower curtains were collapsible at a weight of 40-45kg. However, some patients on Springfield ward were of a lower weight than this making this a potential ligature point.
- The door leading to the female corridor on Chelmer ward remained open and male visitors met with female patients in their bedrooms, which meant male visitors, could see into female bedrooms affecting privacy and dignity.
- One patient in receipt of the addiction therapy programme and detoxification did not have a record of their dependency levels by drug testing prior to administration of treatment to guide prescriptions for detoxification. Two patients did have withdrawal monitoring tools completed to guide continued detoxification treatment.
- Six young people said felt they unsafe on the adolescent ward due to recent incidents that had occurred. However, the provider was managing the incidents and were seeking more appropriate placements for patients requiring a higher levels of security.
- Door closers had metal plates on them that were sharp and easily removed and which could potentially cause harm. We informed the provider of this who removed all remaining metal plates at the time of our inspection.
- Chelmer and Springfield ward had out of date bandages and defibrillator pads which would be required in an emergency. These were replaced on the second day of our inspection.
- Although risk assessments were completed and updated, records were inconsistent between paper and electronic forms and information was difficult to find.

Summary of this inspection

- Although we saw incidents being reported, we did not always find a record of holds staff used during restraints on young people. This information would be required to review incidents of restraint, if an injury occurred or an investigation was required.
- Springfield ward rota showed the ward was understaffed on five occasions. When we raised this with the ward manager, we were told that staff had probably been moved from other wards to cover. However, we were unable to find a record of this on the rota.

However:

- The hospital was very clean with a homely feel. Staff completed daily cleaning schedules, infection control procedures were robust and maintenance issues were addressed promptly.
- Staff received and were up to date with appropriate mandatory training. The majority of training ranged between 92% to 100% compliance.
- The provider used a self-assessment tool to monitor restrictive practice. They completed a restrictive practice audit including an action plan and had a positive behavioural support and reducing restrictive practice strategy.
- The provider had a monthly "learning outcomes" meeting where the provider shared feedback from incidents with the clinical governance committee and staff meetings.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Out of six records reviewed, staff did not record withdrawal symptoms using a recognised tool for two patients.
- The provider did not employ a specialist consultant in addiction to provide oversight and clinical leadership for addiction and prescribing.
- The doctors employed did not have addiction specific qualifications and support staff received training in addictions at induction only.
- Paper records were not always easy to follow and there was inconsistency in content between electronic and paper records. Patient admission checklists on Chelmer ward were not always signed as completed.

However:

- Staff completed care plans for patients and reviewed these regularly. Overall, these were up to date, personalised and holistic.

Summary of this inspection

- Staff completed physical health assessments on admission and there was evidence of on-going monitoring of physical health needs.
- Staff prescribed medication according to the National Institute for Health and Care Excellence guidelines and within recommended guidelines according to the British National Formulary.
- Psychological therapies were available to patients who received individual and group psychological interventions using cognitive behavioural therapy, integrative therapy and existential approaches. Patients with addictions participated in the 12 step programme.
- Patients with nutritional needs were monitored and the provider made arrangements for a dietician to see patients if necessary. Staff assessed and treated eating disorder patients in accordance with the management of really sick patients' anorexia nervosa national guidance.
- Staff interviewed had a good understanding of the Mental Health Act, the Code of Practice and the Mental Capacity Act including assessing Gillick competence for young people.
- Staff read patients their legal rights under the MHA regularly.

Are services caring?

Good

We rated caring as good because:

- Patients and young people completed comment cards which were generally positive about the staff and the provider with eight patients stating they felt safe and the staff were caring.
- Young people were involved in their care plans, they knew most of the staff, received support from advocates and could give feedback to staff.
- Young people received a copy of their care plan and were involved in developing them. There was evidence of family involvement with care plans and risk assessments.
- Patients generally held positive views about the staff at the hospital stating that staff were caring and attentive to their needs.
- We spoke to five carers who stated that the majority of staff were kind and caring.
- Patient satisfaction survey results showed patients were between 81% and 100% satisfied with the service and between 57% and 93% happy with the service.
- Patients were involved in recruitment and attended interviews of new staff.

However:

Summary of this inspection

- Care plans were not consistently signed or offered to patients on Springfield ward and the Lodge.

Are services responsive?

Good

We rated responsive as good because:

- The provider had built an additional therapy room for patients with an eating disorder to eat their meals in private.
- Patients on Springfield ward had a new female only lounge, which was also used by patients on Chelmer ward. There was a mixed lounge for patients from both wards. Young people had their own female and mixed lounge on the ward.
- The provider carried out annual surveys to gain feedback from patients and family/friends with action plans to and timeframes to respond to any identified issues.
- Patients had weekly community meetings and young people had daily community meetings. The senior management team met with patients on a monthly basis for a 'your say forum'.

However:

Young people could not use safes in their bedrooms to store personal possessions as staff were storing banned items in them which only staff could access.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The provider did not ensure robust systems were in place to monitor and treat patients with addictions.
- The provider did not employ a specialist consultant in addiction to provide oversight and clinical leadership for addiction and prescribing.
- The doctors employed did not have addiction specific qualifications and support staff received training in addictions at induction only.
- The provider did not effectively identify all ligature risks on their ligature assessments.

However:

- Staff knew who senior managers were and said they were approachable and visited the provider regularly.
- The provider used an electronic "dashboard", to monitor quality objectives.

Summary of this inspection

- The provider reviewed incidents and complaints at their learning outcome group. The learning outcome group shared lessons learnt with the clinical governance group and at team meetings.
- The provider held morning flash meetings to review the previous day and night where incidents and staffing issues were discussed.
- The provider had systems in place to ensure that staff received regular supervision and support.
- Staff had yearly appraisals and regular team meetings and we saw minutes of these recorded.
- Staff followed safeguarding, Mental Health Act and Mental Capacity Act procedures.
- The provider completed quality 'walk arounds' by senior staff, patients and staff walk arounds to assess and monitor the quality of the hospital.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- At the time of our inspection, six patients were detained under the Mental Health Act 1983.
- The provider had an effective system for checking Mental Health Act (MHA) documentation.
- Staff interviewed had a good understanding of the MHA and the Code of Practice.
- Staff recorded section 17 leave for patients detained under the Mental Health Act, and legal advice on the Mental Health Act was available to staff and patients. Administrative support and legal advice was available to staff within the hospital and from the provider's central team based in Darlington. Eighty eight percent of staff had training in the MHA.
- Consent to treatment and capacity requirements were completed and staff attached forms to medication charts.
- Staff read patients their rights under the MHA regularly. Records showed that patients were reminded of their legal rights regarding section 132 of the Mental Health Act 1983.
- The provider ensured detention paperwork was filled in correctly, up to date and stored appropriately. The MHA administrator checked MHA paperwork on admission to ensure accuracy and audited these to ensure the MHA was being applied correctly. Learning from audits were shared with staff to improve MHA practice.
- Patients had access to independent mental health advocates (IMHAs) who visited the provider regularly and were available on request. We spoke with one IMHA who told us patients were informed of their rights and used the IMHA services well, particularly on Springfield ward.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Ninety four percent of staff had training in the Mental Capacity Act, 2005. Staff generally demonstrated a good understanding of the MCA.
- No patients were subject to a Deprivation of Liberty Safeguards application during our inspection.
- Staff had completed decision specific capacity assessments for patients lacking the capacity to do so themselves. Staff recorded best interest decisions in patient records detailing the five statutory principles. The multi-disciplinary team held best interest meetings where necessary and family and carers were invited. Staff completed Gillick Competency assessments for young people.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Child and adolescent mental health wards	Requires improvement	Good	Good	Good	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

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

Requires improvement

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are acute wards for adults of working age and psychiatric instensive care unit services safe?

Requires improvement

Safe and clean environment

- Chelmer, Springfield ward and the Lodge ward layouts had blind spots where staff could not easily observe patients. Staff could not observe patients in corridors or bedrooms as doors did not have glass panels. The location of both ward offices did not enable staff to observe all parts of the ward. The male bedrooms on Chelmer ward were upstairs. There were no mirrors to improve observation of blind spots. However, staff mitigated this risk by completing regular observations of patients at high risk of harm and completing risk assessments for patients staying at the Lodge.
- The provider had completed ligature risk assessments for each room, which staff had rated and were in date. However, towel and soap dispensers seen in one bedroom were recorded as "not present" on the ligature risk assessment. Wardrobes had grooves in them where hangers were placed making them weight bearing. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The provider had not identified these as a risk on the ligature assessment. Door handles in the mixed lounge were not identified as a ligature point. We informed the provider who removed these at the time of our inspection. Door closers were found in the female lounge shared by Chelmer and Springfield ward and were recorded as "not present" on the audit. Staff identified door closers in the reception area and the doors leading to the male corridor on Chelmer ward on the ligature assessment but rated these as a low risk. The shower curtains were collapsible at a weight of 40-45kg. However, some patients on Springfield ward were of a lower weight than this making this a potential ligature point. However, the provider managed these risks with increased levels of observation for high-risk patients and regular hourly environment checks. Two safer rooms identified by staff on both wards had ligature points that were not identified on the assessment including the fixings used to attach the toilet roll holder to the wall and the wardrobe grooves to hold hangers.
- We found some door closers had metal plates on the front of them that were missing. These plates could be easily removed and had very sharp edges that could be used to cause harm. We informed the provider of this who removed all remaining metal plates at the time of our inspection.
- Springfield ward left corridor doors open leading in to Chelmer ward so it was unclear where Springfield ward ended and Chelmer ward started. When we asked the provider if patients moved freely between the wards, we were told they tended not to. However, we were unable to confirm this.
- Both wards complied with same sex accommodation where male and female sleeping areas were segregated. All bedrooms had en-suite facilities and there were separate lounges for men and women. However, the door leading to the female corridor on Chelmer ward remained open and male visitors met with female patients in their bedrooms, which meant male visitors, could see in to female bedrooms affecting privacy and dignity.

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

Requires improvement

- Chelmer and Springfield ward shared the clinic and treatment rooms between the two ward areas. The clinic room was equipped and emergency drugs were present. The emergency bag (necessary equipment for use in an emergency) was kept in the nursing office on Chelmer ward. However, the defibrillator pads and some bandages were out of date. We informed the provider who replaced these on the second day of our inspection.
- The provider was very clean with a homely feel. Cleaning schedules were in place and completed daily. The provider had infection control procedures in place and addressed maintenance issues promptly.
- The provider completed environmental risk assessments and regular fire safety checks and fire drills took place. The provider had trained 33 staff as fire marshals and nine staff were first aid trained
- Health and safety minutes were reviewed and demonstrated robust systems in place to review and address any health and safety matters within the hospital.
- Staff had access to appropriate alarms and nurse call systems were available in every room.

Safe staffing

- Data between 15 June 2016 and 15 September 2016 showed the provider had 25 qualified nurses and 41 nursing assistants in post. The provider had nine qualified nurse vacancies and 1.5 nursing assistant vacancies.
- Between 15 June 2016 and 15 September 2016 there were 181 shifts filled by bank and agency staff to cover sickness, absences or vacancies. There were no shifts between this period that were not filled.
- The provider made all attempts to use regular agency staff who were familiar with the provider and block booked one agency staff member to aid consistency of care.
- Data showed that in the last twelve months from 1 September 2016, there were 41 staff leavers. Concerns were raised to us leading up to the inspection about staffing levels and the provider gave an overview of reasons for staff leavers which tended to relate to personal issues such as child care, distance to travel, professional development or career progression. We also reviewed six exit questionnaires that matched reasons specified for leaving.
- The provider used a staffing model to predict the ratio of nurse to patients across all services. For Springfield and the adolescent ward, the ratio was one staff to three patients, and on the acute ward, it was one staff for four patients. The provider increased staffing levels if additional staff were required for constant observations to manage patient risks.
- We reviewed staff rotas and found staff to patient ratios were achieved for Chelmer ward and the Lodge. However, on Springfield ward the ward was understaffed for the 9 November 2016 and 26 November 2016 by two staff. Night rotas indicated staffing levels were not always met. On the 5 December 2016, the ward was understaffed by two staff at night. On the 27 November 2016 and 3 December 2016, rotas showed that the ward only worked with three staff on the late shift. When we raised this with the ward manager, we were told that staff had probably been moved from other wards. However, we were unable to find a record of this on the staff rota.
- Ward managers told us they were able to adjust staffing levels daily. Managers met every morning for a 'flash meetings' where staffing levels were discussed and organised so that staff available on other areas or bank or agency staff were sought to cover wards. We saw one manager on Chelmer ward book staff in advanced for shifts they had been unable to fill the following day.
- Staffing levels were sufficient to facilitate one to one time with patients.
- Staff rarely cancelled escorted leave and activities due to staff shortages.
- Medical staff could attend the wards quickly in an emergency. Doctors were available throughout the day and night and the provider had an on call rota showing how the provider was staffed 24 hours a day.
- Staff received and were up to date with appropriate mandatory training. The majority of training ranged between 92% to 100% compliance. Team leader equality and diversity training was the only training level that fell below 75% at 70% compliance. The provider told us they had worked to increase this training, which at the time of the inspection, increased to 73%. However, the provider stated that the online training had recently been unavailable which had affected the rating.

Assessing and managing risk to patients and staff

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

Requires improvement

- The provider did not have a seclusion room and there were no reported incidents of seclusion or long-term segregation in the last six months between 1 March 2016 and 1 September 2016.
- The provider had seven incidents of restraint on Chelmer ward involving six patients and 17 incidents of restraint involving two patients on Springfield ward for nasal gastric feeding, in accordance with their care plans. The Lodge had no incidents of restraint in the last six months between 1 March 2016 and 1 September 2016.
- The provider did not restrain any patients in the prone position in the last six months between 1 March 2016 and 1 September 2016. Eighty seven percent of staff were trained in non- prone restraint.
- The provider had no recorded incidents of rapid tranquilisation in the last six months between 1 March 2016 and 1 September 2016.
- Whilst reviewing health and safety minutes and staff personnel files we saw three RIDDOR reportable incidents where injuries occurred to staff during restraints. RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. These Regulations require employers, the self-employed and those in control of premises to report specified workplace incidents. The provider had reported these and supported staff through staff support, occupational referrals, writing to and meeting with staff who had been injured.
- The provider used a self-assessment tool to monitor restrictive practice, completed a restrictive practice audit including an action plan and had a positive behavioural support and reducing restrictive practice strategy.
- We examined 18 records for Chelmer ward, Springfield ward and the Lodge. Although risk assessments were completed and updated, records were inconsistent between paper and electronic forms and information was difficult to find. Springfield ward did not refer to eating disorder risks in risk assessments. However, these were recorded in multi-disciplinary team (MDT) reviews, which detailed 'other risks' to include eating disorder risks. One patient in receipt of the addiction therapy programme and detoxification did not have a record of their dependency levels by drug testing prior to administration of detoxification to guide prescriptions for detox. Records for two patients receiving detoxification did not include all required assessment information to guide withdrawal management for detoxification treatment. UK guidelines on the clinical management of drug misuse and dependence (2007) state the 'aims of a full or comprehensive assessment should include confirming the patient is taking drugs (history, examination and drug testing) and assessing degree of dependence'. Guidelines also state 'drug testing should be Initial assessment and confirmation of drug use (although testing does not confirm dependence or tolerance and should be used alongside other methods of assessment)'.
- Although we were told informal patients could leave at will and the provider had signs on access-controlled doors informing patients of this, one informal patient told us they were not aware that they could leave when they wanted to. We fed this back to the provider who said they would discuss this with the patient.
- The provider had policies and procedures in place for the use of observations and searching patients.
- The provider used a self-assessment tool to monitor restrictive practice, which was discussed at clinical governance meetings. The provider had a positive behavioural support and reducing restrictive practise strategy (2015) in place, which included a restrictive practise audit with action plan.
- Staff were trained in safeguarding with compliance rates of 96% for safeguarding children and 93% for safeguarding adults. When we spoke to staff they knew how to make safeguarding alerts and the provider had a clear process for monitoring with local authorities and remaining up to date with all alerts made.
- We reviewed 27 prescription charts. The provider had good medicines management practices with safe prescribing and administration. However, out of 16 charts viewed on Chelmer ward, only two recorded whether patients had allergies and eight charts did not have a photo of the patient. Staff unfamiliar with the ward might have difficulty identifying patients when administering medication.
- The provider had a room for children visiting the provider although visits generally took place in patient's bedrooms. The provider stated that children should be accompanied by an adult when visiting. The provider had a policy in place, which ensured safe child visits.

Track record on safety

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

Requires improvement

- The provider reported 14 serious incidents between Chelmer ward and the Adolescent ward. Self-harm was the most frequent incident particularly on the adolescent ward followed by absconsions and aggression and violence.

Reporting incidents and learning from when things go wrong

- Staff knew what to report and how to report incidents although support workers did not have access to the incident reporting system, and had to ask qualified nurses to report incidents. The clinical manager reviewed all reported incidents within 48 hours. The central quality and safety team also reviewed incidents and referred back to site with any queries or share lessons learned. The clinical governance committee reviewed all incidents each month and shared information across the Priory group.
- The provider reviewed serious incidents and made improvements to reduce the incidents of self-harm by holding search training days for health care assistants to ensure banned items were removed from belongings, rooms or patients. To reduce incidents of absconsion, the provider completed further training in risk assessing and risk management with staff.
- The provider had a monthly learning outcomes meeting where incidents fed into the clinical governance committee meeting where the learnings were discussed and shared. Both of these meetings were disseminated into staff meetings.
- The provider had made improvements to the environment for patient safety. For example, an internal corridor had been constructed to ensure high-risk patients could access the dining room without going outside the building. The provider also built a new fence around the garden, therefore reducing the risk of absconsion. To manage and improve on aggression and violence incidents, the provider reviewed the referral information requested of referrers to ensure that referrals to the hospital were suitable. An audit was undertaken with staff to determine whether additional restraint training was required to manage violence and aggression.
- Staff followed duty of candour principles and were open and honest when providing feedback to patients and families.
- The therapy team provided support and debriefs to staff, following incidents.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Staff completed comprehensive and timely assessments of patient needs on admission.
- Staff completed physical health assessments on admission and there was evidence of on-going monitoring of physical health problems.
- Overall, staff completed personalised and holistic care plans for patients and reviewed these regularly. However, out of six records for patients on Springfield ward, three patients' records were not as detailed. Records for patients receiving detoxification on Chelmer ward and treatment at the Lodge did not include all required assessment information. For example, out of six records reviewed, two patients did not have a withdrawal monitoring tool recorded and one patient did not have a urine drug test on admission to guide withdrawal management for individual patients and patients receiving detoxification treatment.
- The provider stored patient information securely. Staff had access to patient information via electronic and paper records. However, the paper records were not always easy to follow and there was inconsistency in content between electronic and paper records. Patient admission checklists on Chelmer ward were not always signed as completed.

Best practice in treatment and care

- Staff prescribed medication according to the National Institute of Health and Care Excellence guidelines and within recommended guidelines according to the British National Formulary. However, prescribing for addictions was not linked with appropriate monitoring and assessment tools.
- Psychological therapies were available to patients who received individual and group psychological interventions using cognitive behavioural therapy and

integrative therapy. Patients with addictions had psychological interventions from CBT, Integrative and existential approaches and participated in the 12 step programme.
- Patients had access to physical healthcare including specialists when needed. Staff referred patients to their general practitioner for physical health concerns.
- Patients with nutritional needs were monitored and the provider sourced a dietician to see patients if necessary. Patients on Springfield ward for eating disorders were on diet plans in accordance with the provider policy and the Management of Really Sick Patients with Anorexia Nervosa guidance (MARSIPAN) (Royal College of Psychiatrists, 2014). Nasal gastric feeding was conducted in line with medical feedback from blood monitoring and
- medical checks and increments to feeding were made in line with MARSIPAN guidance.
- Staff used the Health of the Nation Outcome Scale to assess and record severity and outcomes (HoNOS). However, staff did not fully complete HoNOS assessments and did not have computer access to the entire assessment.

Skilled staff to deliver care

- The team included registered mental health nurses and support workers, consultants, doctors, occupational therapists, a pharmacist, a dietician, psychologists, counsellors and therapists. However, there was no social worker but the provider was due to recruit in to this post.
- The provider had a specialist eating disorder and child and adolescent mental health consultant but did not have a specialist consultant for the addictions treatment programme at the hospital. Doctors did not have specialist qualifications in addiction treatment and one doctor had no knowledge of the UK guidelines on clinical management of drug misuse and dependence (Department of Health 2007). UK guidelines on the clinical management of drug misuse and dependence (2007) state 'clinicians need to ensure that they have been trained to gain the appropriate competencies to treat drug misusers'.
- All new staff completed an induction and support assistants completed the care certificate training.
- Staff received regular supervision in individual and group sessions and all staff received an appraisal. Staff had access to regular team meetings.
- Staff received training relevant to their role including eating disorder training and nasal gastric tube administration on Springfield ward and managers had the opportunity to complete leadership training. However, support staff training, specifically in addictions, was minimal staff received training in addictions at induction only
- Poor staff performance was addressed promptly and effectively.

Multi-disciplinary and inter-agency team work

- The provider held weekly multi-disciplinary team (MDT) meetings to discuss patients' care and treatment.
- Staff received comprehensive handovers to keep up to date with patient care needs.
- The provider worked with external agencies including local authorities, the GP, and local authority safeguarding teams.
- The provider followed the framework of the care programme approach (CPA). Community teams were encouraged to attend hospital-based meetings and to maintain contact and involvement with the patient.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- There was an effective system in place for checking Mental Health Act (MHA) documentation.
- Staff interviewed had a good understanding of the MHA and the Code of Practice.
- Staff recorded section 17 leave for patients detained under the Mental Health Act, and legal advice on the mental health act was available to staff and patients.
- Eighty eight percent of staff had training in the Mental Health Act 1983 (MHA).
- Consent to treatment and capacity requirements were completed and staff attached forms to medication charts.
- Staff read patients their rights under the MHA regularly. Records showed that patients were reminded of their legal rights regarding section 132 of the Mental Health Act 1983. Administrative support and legal advice was available to staff within the hospital and from
- the provider's central team based in Darlington.
- Detention paperwork was filled in correctly, up to date and stored appropriately. The MHA administrator checked MHA paperwork on admission to ensure accuracy and audited these to ensure the MHA was being applied correctly, which included rights being

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

Requires improvement

read every two months, access to independent mental health advocates (IMHA) and section 17 leave. Learning from audits were shared with staff to improve MHA practice.

- Patients had access to Independent Mental Health Advocates (IMHA's) who visited the provider regularly and were available on request. We spoke with one Independent Mental Health Advocate (IMHA) who told us patients were informed of their rights and used the IMHA services well, particularly on Springfield ward.

Good practice in applying the MCA

- Ninety Four percent of staff had training in the Mental Capacity Act, 2005 (MCA). Staff generally demonstrated a good understanding of the MCA.
- No patients were subject to a Deprivation of Liberty Safeguards application during our visit.
- Staff had completed decision specific capacity assessments for patients lacking the capacity to do so themselves. Staff recorded best interest decisions in patient records detailing the five statutory principles. The multi-disciplinary team (MDT) held best interest meetings where necessary and family and carers were invited.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, dignity, respect and support

- We spoke to 20 patients who generally held positive views about the staff at the hospital stating that staff were caring and attentive to their needs. However, some patients felt there could be more activities and a gym for patients to use.
- We spoke to five carers who stated that the majority of staff were kind and caring.
- Patients completed 16 comment cards which were generally positive about the staff and the hospital, with eight patients stating they felt safe and the staff were caring. The provider's cleanliness and hard work of the housekeeping staff was commented on positively. Patients felt care was individualised and the majority of staff were compassionate. However, some patients felt a change to the shift pattern had a negative impact on the ward, some staff can be inconsistent in their responses to situations, communication amongst staff could improve and more staff were required.
- The provider received an overall rating of 5 stars on the NHS choice website completed by two participates on the quality of cleanliness, staff co-operation, dignity and respect, involvement in decisions and same sex accommodation at the hospital.

The involvement of people in the care they receive

- Out of 18 records we reviewed, three out of six patients on Chelmer ward received a copy of their care plan and three refused. However, staff had set a date to attempt to offer patients a copy of their care plan on another occasion. On Springfield ward out of six care plans three patients had received a copy but only one had signed their care plan. Out of six records for patient with addictions, two patients had signed their care plans.
- Families and carers we spoke to said they were involved and kept informed of their relatives care and treatment. Families and carers were invited to multi-disciplinary team meetings to give their input.
- Patients completed satisfaction surveys at discharge. Questions surrounded their experience of admission, their stay, discharge, communication and meetings with staff, involvement with their care plans, medication and dignity and respect. Overall results in the last 12 months showed patients were between 81% and 100% satisfied with the service and between 57% and 93% happy with the service.
- Patients were involved in recruitment and attended interviews of new staff. In September 2016, two patients were involved in recruitment interviews for four staff for Springfield and the adolescent wards.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

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

Requires improvement

- The provider's average bed occupancy for the last six months from 1 March 2016 to 1 September 2016 was 98% for Chelmer ward and 100% for Springfield ward.
- Care pathways and admissions were from other inpatient units or various parts of the United Kingdom due to placements not being available in patient's home areas to meet their needs.
- Average length of stay for patients at 1 September 2016 was 81 days on Chelmer ward, 207 days on Springfield ward and 28 days for patients with addictions.
- Admissions and discharges were planned in advance. Staff said they could receive inappropriate referrals and patients needed a higher level of care, which they would refuse admission for if they felt they could not meet the needs of the patient.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider had recently built a therapy room for patients with an eating disorder to eat their meals in private. The room was comfortable, bright and had blinds for the purpose of privacy and dignity.
- The clinic room was large and well equipped and had a separate treatment room next door.
- Springfield ward had a new female only lounge, which was also used by patients on Chelmer ward, and there was a mixed lounge for both wards to use.
- Visitors used bedrooms for visits or the multi faith room where child visits could also take place. However, on Chelmer Ward, male visitors met with female patients in their bedrooms. When female bedroom doors were open, male visitors could see into the bedrooms. This was a breach of the privacy and dignity of those patients.
- Patients had phones in their bedrooms, which they could pay to use when required, or they could keep and use their own mobile phones and use computers.
- Patients had access to outside space for fresh air when required.
- Patients complimented the food and the catering department had regular meetings with patients to discuss the food and menu choices. Dietary needs were met.
- Patients had access to areas within the wards where they could make hot drinks and a snack if required. We saw fruit available for patients.
- Patients were able to personalise bedrooms and we saw several patients' rooms that were personalised to their taste.
- Patients had safes in their rooms and lockable cupboards where they could store their possessions.
- Patients had access to a variety of activities including at weekends.

Meeting the needs of all people who use the service

- There was one patient in a wheelchair on Springfield ward who could move around and had access to the building. However, male patients with mobility issues could not easily move around Chelmer ward as male patient's bedrooms were upstairs and there was no lift. The provider said that they would use two bedrooms in the female corridor to maintain privacy and dignity and meet the needs of the male patient requiring disabled access.
- Information leaflets were available on request in different languages if required.
- Information on patients' rights, treatment, how to complain, advocacy and safeguarding were available for patients
- Staff had access to interpreters, when needed, to aid communication with patients whose first language was not English.
- Patients were provided with food to meet dietary requirements and cultural needs. Meal choices included options for gluten free, vegan and halal diets.
- The provider had a multi faith lead who liaised with local spiritual communities and leaders. Each patient was given an information card regarding faith on admission which detailed support with different religious faiths.

Listening to and learning from concerns and complaints

- The provider had 28 complaints within the last 12 months. Complaints included dissatisfaction with patient assessment in outpatient clinics and a lack of consultation with addiction patients regarding a change.
- Eight complaints were upheld or partially upheld.
- The provider received 36 compliments in the last 12 months from 1st September 2016. Ten were for Chelmer ward.

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

Requires improvement

- Systems were in place for managing and dealing with complaints with information provided to staff and patient.
- There were systems for processing and monitoring and responding to complaints and saw evidence of this. Staff told us that any learning from complaints was shared with the staff team.
- Records of complaints including outcome response letters to carers. These were open honest and demonstrated the principles of the duty of candour.
- Discharge questionnaires were offered for patients to give feedback. The provider carried out annual surveys to gain feedback from patients and family/friends with action plans to and timeframes to respond to any identified issues.
- Patients had weekly community meetings where the senior management team met with patients on a monthly basis for a 'your say forum' where feedback was written and actioned on a 'you say, we did' board so it was clear to patients what action was taken following their feedback.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Requires improvement

Vision and values

- The provider had a clear set of organisational values including putting people first, being a family, acting with integrity, being positive and striving for excellence.
- Staff knew who senior managers were and said they were approachable and visited the provider regularly. The executive team visited each site in August 2015 in order to present the new purpose and values. Follow up visits took place in April 2016. All staff were invited to attend these roadshows. In addition, the company sent a copy of the purpose and behaviours to every employee in the company with their wage slip. Posters were displayed at site and "credit cards" available for staff detailing the purpose and expected behaviours. The purpose and expected behaviours had also been integrated into the new Care Certificate workbooks.

Good governance

- The provider did not ensure robust systems were in place for the treatment and monitoring of patients with addictions including providing drug testing on admission and withdrawal monitoring to guide detoxification prescribing. UK guidelines on the clinical management of drug misuse and dependence (2007) state services should be 'provided with consistent national guidance and principles, and in line with the evidence base' and a 'timely and regular audit and review cycle should be in place'.
- The provider did not ensure medical staff had specialist qualifications to provide treatment for addictions or a doctor to lead in addictions. Support staff did not have sufficient training in addictions only receiving this at induction. UK guidelines on the clinical management of drug misuse and dependence (2007) specify that 'clinicians working with drug misusers must be appropriately competent, trained and supervised'.
- The provider used an electronic "dashboard", to monitor quality objectives, human resource information, finance and occupancy. Monthly scorecards were also distributed on mandatory training, incidents, complaints, regulatory issues and medicines.
- The provider had a compliance manager who monitored quality data such as risk assessments and care plans to ensure they are up to date.
- The provider had a learning outcome group where incidents and complaints were reviewed and lessons learnt disseminated to the clinical governance meetings and team meetings.
- Morning flash meetings were held to review the previous day and night where incidents and staffing issues were discussed. These were attended by senior managers, ward managers and staff. Senior manager met weekly in a group and had individual meetings with the director.
- The provider had systems in place to ensure that staff received regular supervision and support. Supervision data from 1 September 2015 to 1 September 2016 showed a 90% compliance rate which did not meet the provider target of 95%. However, we reviewed supervision records on wards and found that staff appeared to have regular individual or group supervision.
- Staff had yearly appraisals and regular team meetings and we saw minutes of these recorded.
- Staff followed safeguarding, Mental Health Act and Mental Capacity Act procedures.

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

Requires improvement

- The provider's risk register highlighted safety concerns, identified actions to resolve these with timeframes for completion. On-going risk were identified.

Leadership, morale and staff engagement

- The top three issues from the results of the staff survey included; staff feeling valued in the work they do, staff having the equipment and resources to do the job properly and staff receiving the training and development they needed to do the job well. The provider had submitted an action plan with timeframes to address these.
- There were no reported bullying and harassment cases and staff said they worked well as a team. Staff knew how to raise concerns if they needed to without fear of victimisation.
- Staff were open and transparent with patients and we saw that duty of candour was exhibited when the service had made mistakes.
- The provider had processes to monitor staff sickness and absence .
- There were opportunities for staff to engage in further development, for example leadership courses and further development.
- Most staff reported good multi-disciplinary team (MDT) working and being able to approach their managers with any concerns or feedback and feeling supported by them. The provider had out of hours on call rotas for senior nurses, managers and doctors for staff to contact if needed.

Commitment to quality improvement and innovation

- The provider had completed quality improvement objectives for 2016 with actions and targets for future improvements.
- The provider completed quality walk rounds by senior staff, service users and staff to record the quality of the hospital.
- Staff, patients and carers were able to nominate staff members for awards where staff were recognised for their contributions to the service.
- Springfield ward had received accreditation for the Quality Network for Eating Disorders (QED). Hospital accreditation is awarded when the ward meets a specified number of standards.

Requires improvement

Child and adolescent mental health wards

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are child and adolescent mental health wards safe?

Requires improvement

Safe and clean environment

- The Adolescent ward was on two floors, with the entrance upstairs and access to the garden downstairs. The ward had blind spots where staff could not easily see all parts of the ward. However, staff managed this with CCTV and staff observations of patients.
- The provider had completed ligature risk assessments for each room which were rated and in date. However, the garden did not have a ligature assessment and trees and garden furniture were not identified as ligature points. Wardrobes had grooves in them where hangers were placed making them weight bearing. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. These presented as a potential ligature point and were not identified as a risk on the ligature assessment. Safer rooms had ligature points that were not identified on the ligature assessment including the wardrobe grooves. The provider had identified other ligature points in their ligature audit and these were mitigated for by individual risk assessments and staff observation of patients.
- There had recently been several difficult incidents on the adolescent ward including young people absconding from fire exits and aggression towards staff. Six young people referred to these incidents and told us these were causing them additional distress and to feel unsafe on the ward. Two young people said that young people had been intervening in restraints during recent incidents. However, the provider was managing the incidents and were seeking more appropriate placements for patients requiring higher levels of security.
- The ward complied with same sex accommodation where male and female sleeping areas were segregated. All bedrooms had en-suite facilities and there were separate lounges for male and female young people. However, the female lounge had recently been built and the glass for the windows and door were not yet installed, meaning males could see in to the female lounge.
- The clinic room located on the upstairs floor of the adolescent ward had recently been built but had not yet been used. The clinic room was well equipped, emergency medication and the emergency bag were available.
- The ward was very clean with a homely feel. Cleaning schedules were in place and completed daily. Cleanliness and infection control procedures were robust and maintenance issues identified were addressed promptly.
- Ward and hospital environmental risk assessments took place. Fire safety checks and fire drills took place.
- Health and safety minutes were reviewed and demonstrated robust systems in place to review and address any health and safety matters within the hospital.
- Staff had access to appropriate alarms and nurse call systems were available in every room.

Safe staffing

Requires improvement

Child and adolescent mental health wards

- Data between 15 June 2016 and 15 September 2016 showed the provider had 25 qualified nurses and 41 nursing assistants in post. The provider had 9 qualified nurse vacancies and 1.5 nursing assistant vacancies.
- Between 15 June 2016 and 15 September 2016 there were 181 shifts filled by bank and agency staff to cover sickness, absences or vacancies. There were no shifts between this period that were not filled by bank or agency staff.
- The provider made all attempts to use regular agency staff who were familiar with the provider and block booked one agency staff member to aid consistency of care. Data submitted to us on the 1 September 2016 showed out of 150 substantive staff there was a three percent sickness rate of permanent staff
- Data showed that in the last twelve months from 1st September 2016, there were 41 staff leavers. Concerns were raised to us leading up to the inspection about staffing levels and the provider gave an overview of reasons for staff leavers which tended to relate to person issues such as We also reviewed six exit questionnaires which matched reasons specified for leaving.
- The provider used a staffing model to predict the ratio of nurse to patients on different services. On the adolescent ward, the ratio was one staff to three patients. This was increased if additional staff were required for constant observations to manage patient risks.
- We reviewed rotas on the adolescent ward from 21 November 2016 to 4th December 2016 prior to our inspection and found rotas matched the staffing ratios set by the provider. We could see where numbers had been adjusted according to patient observations levels and it was recorded where staff had been moved to support other wards with staffing.
- The ward manager told us they were able to adjust staffing levels daily. Staffing levels were discussed daily in morning 'flash meetings' and staff were sought from within the hospital if extra staff were available.
- Staffing levels were sufficient to facilitate one to one time with patients.
- Staff rarely cancelled escorted leave and activities due to staff shortages.
- Doctors were available throughout the day and night and the provider had an on call rota with doctors staying at the Lodge overnight.
- Staff received and were up to date with appropriate mandatory training. The majority of training fell between 92% to 100% compliance. Team leader equality and diversity training was the only training level that fell below 75% at 70% compliance. The provider stated that they had worked to increase this training, which at the time of the inspection increased to 73%. However, the provider stated that the online training had recently been unavailable which had affected the rating but they were working towards increasing this.

Assessing and managing risk to patients and staff

- The provider did not have a seclusion room and there were no reported incidents of seclusion in the last six months between 1 March 2016 and 1 September 2016.
- The adolescent ward had the highest incidents of patient restraint at 37, involving ten young people in the six months between 1 March 2016 and 1 September 2016.
- The provider reported they had not restrained any patients in the prone position in the last six months between 1 March 2016 and 1 September 2016. However, when we checked incident records we found one incident of prone restraint lasting ten minutes, which led to a member of staff being injured. The provider reported this as a RIDDOR. RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. These Regulations require employers, the self-employed and those in control of premises to report specified workplace incidents.
- The provider completed incident reports when young people were restrained. However, not all incidents were fully completed and did not identify individual staff member's involvement during the restraint. This information might be needed should an investigation be required.
- Eighty seven percent of staff were trained in non- prone restraint.
- The provider had no recorded incidents of rapid tranquilisation in the last six months between 1 March 2016 and 1 September 2016.
- The provider used a self-assessment tool to monitor restrictive practice, completed a restrictive practice audit including an action plan and had a positive behavioural support and reducing restrictive practice strategy.
- We reviewed five care records and found risk assessments were completed and updated regularly.

- The provider used a self-assessment tool to monitor restrictive practice, which was discussed at clinical governance meetings. The provider had a positive behavioural support and reducing restrictive practise strategy (2015) in place, which includes a restrictive practise audit with action plan.
- The provider had signs informing informal patients of their rights to leave on access-controlled doors which staff would open on request.
- The provider had policies and procedures in place for the use of observations and searching patients.
- Staff were trained in safeguarding with compliance rates of 96% for safeguarding children. When we spoke to staff they knew how to make safeguarding alerts and the provider had a clear process for monitoring with local authorities and remaining up to date with all alerts made.
- We reviewed 17 prescription charts. The provider had good medicines management practices with safe prescribing and administration.
- The provider had a room for children visiting the provider although visits generally took place in patient's bedrooms. The provider states that children should be accompanied by an adult when visiting. The provider had a policy in place, which ensured safe child visits.
- During our inspection, the ward was very busy, noisy and presented as a high stimulus environment. Staff were responding to incidents at the time of our inspection and some young people told us they felt unsafe due to recent incidents on the ward.

Track record on safety

- There have been eight serious incidents on the adolescent ward. Self-harm was the most frequent incident followed by absconsion and aggression and violence.

Reporting incidents and learning from when things go wrong

- Staff knew what to report and how to report incidents although support workers did not have access to the incident reporting system, and had to ask qualified nurses to report incidents. Once staff logged incidents, the Clinical Manager reviewed them within 48 hrs. The central quality and safety team also reviewed incidents and would refer back to site with any queries or share lessons learned. The clinical governance committee reviewed all incidents each month and shared information across the Priory group.
- The provider reviewed serious incidents and made improvements to reduce the incidents of self-harm by holding search training days for health care assistants to ensure banned items were removed from belongings, rooms or patients. To reduce incidents of absconsion, the provider completed further training in risk assessing and risk management with staff.
- The provider had a monthly learning outcomes meeting where incidents fed into the Clinical Governance committee meeting where the learnings were discussed and shared. Both of these meetings were disseminated into staff meetings. The provider had made improvements to the environment for patient safety. For example, an internal corridor had been constructed to ensure high-risk patients could access the dining room without going outside the building. The provider also built a new fence around the garden, therefore reducing the risk of absconsion. To manage and improve on aggression and violence incidents, the provider reviewed the referral information requested of referrers to ensure that referrals to the site were suitable. An audit was undertaken with staff to determine whether additional restraint training was required to manage violence and aggression.
- Staff followed duty of candour principles and were open and honest when providing feedback patients and families.
- The provider had monthly learning outcomes meetings where incidents fed into the Clinical Governance committee meeting where the learnings were discussed and shared. Both of these meetings were disseminated into staff meetings.
- Following a call to a carer, as part of the inspection process, a parent disclosed to us that a serious incident had occurred on the ward during the night shift of the 9 December 2016, which involved absconsion, racial and physical aggression towards staff and involved the police. However, the provider had assured us the ward has been made safe. Alternative placements for young people were being sought. All families were informed of the situation. Young people and staff were supported and offered de-briefs which were continuing.
- The therapy team provided support and debriefs to staff following incidents.

Requires improvement

Child and adolescent mental health wards

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Staff completed comprehensive and timely assessments of patient needs on admission.
- Staff completed physical health assessments on admission and there was evidence of on-going monitoring of physical health problems.
- Overall, staff completed personalised and holistic care plans for patients and reviewed these regularly.
- The provider stored patient records securely. Staff had access to patient information in both electronic and paper records. However, the paper records were not always easy to follow and there was inconsistency in content between electronic and paper records.

Best practice in treatment and care

- Staff prescribed medication according to the National Institute of Clinical Excellence (NICE) guidelines for young people and within recommended guidelines according to the British National Formulary (BNF).
- Psychological therapies were available to patients who received individual and group psychological interventions using cognitive behavioural therapy and dialectic behavioural therapy.
- Patients have access to physical healthcare including specialists when needed. Staff referred patients to their general practitioner for physical health concerns.
- Patients with nutritional needs were monitored and the provider sourced a dietician to see patients if necessary.
- Staff used the Health of the Nation Outcome Scale for Children and Adolescents to assess and record severity and outcomes (HONOSCA) although the first part was only filled in and clusters were not completed. Staff also used the Children's Global Assessment Scale (CGAS), a nationally recognised assessment tool.

Skilled staff to deliver care

- The team included registered mental health nurses and support workers, consultants, doctors, occupational therapists, a pharmacist, a dietician, psychologists, counsellors and therapists. However, there was no social worker but the provider was due to recruit into this post.
- The provider had a specialist child and adolescent mental health consultant.
- All new staff completed an induction and healthcare support assistants completed the care certificate training.
- Staff received regular supervision in individual and group sessions and all staff received an appraisal. Staff had access to regular team meetings.
- Staff received training relevant to their role including positive behaviour support training.
- The provider had systems to address poor staff performance effectively.

Multi-disciplinary and inter-agency team work

- The provider held weekly multi-disciplinary (MDT) meetings to discuss patients' care and treatment.
- Staff received comprehensive handovers to keep up to date with patient care needs.
- The provider worked with external agencies including local authorities, the GP, and local authority safeguarding teams.
- The provider followed the framework of the care programme approach (CPA). Community teams were encouraged to attend provider-based meetings and to maintain contact and involvement with the patient.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- There was an effective system in place for checking Mental Health Act (MHA) documentation.
- Staff interviewed had a good understanding of the MHA and the Code of Practice.
- Staff recorded section 17 leave for patients detained under the MHA and legal advice on the MHA was available to staff and patients.
- Eighty- eight percent of staff had training in the Mental Health Act 1983 (MHA).
- Consent to treatment and capacity requirements were completed and staff attached forms to medication charts.
- Staff read patients their rights under the MHA regularly. Records showed that patients were reminded of their

legal rights regarding section 132 of the Mental Health Act 1983. Administrative support and legal advice is available to staff within the hospital and from the provider's central team based in Darlington.
- Detention paperwork was filled in correctly, was up to date and stored appropriately. The MHA administrator checked MHA paperwork on admission to ensure accuracy and audited these to ensure the MHA was being applied correctly. Auditing included ensuring patients' rights were being read every two months and staff were reminded if this had not occurred. Access to independent mental health advocates (IMHA) and section 17 leave was reviewed. Learning from audits was shared with staff to improve MHA practice.
- Patients have access to IMHA's who visit the provider regularly and were available on request. We spoke with one IMHA who told us patients were informed of their rights and used the IMHA service well.

Good practice in applying the Mental Capacity Act

- Ninety four percent of staff had training in the Mental Capacity Act, 2005 (MCA). Staff generally demonstrated a good understanding of the MCA.
- No patients were subject to a Deprivation of Liberty Safeguards application during our visit.
- Staff had completed decision specific capacity assessments for patients lacking the capacity to do so themselves. Staff recorded best interest decisions in patient records detailing the five statutory principles. The multi-disciplinary team (MDT) held best interest meetings where necessary and family and carers were invited.
- Gillick competence assessments were referred to and completed for young people. Children under 16 years need to be assessed whether they have enough understanding to make up their own mind about the benefits and risks of treatment – this is termed 'Gillick competence'.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

- We observed caring interactions by staff towards young people.
- We spoke to six young people who said that staff ignored them, were not helpful or compassionate when people were self-harming and they received more information from other young people rather than staff.
- We spoke with two parents of young people. One parent felt their child was safe on the ward and there was enough staff except in the evenings. Parents said the environment was clean. However, one parent referred to a recent incident at night involving absconsion of young people and verbal and physical aggression towards staff. This was discussed with the provider who had taken steps to manage the situation and make the ward safe.
- Patients completed 16 comment cards, which were generally positive about the staff and the provider with eight patients stating they felt safe and the staff were caring. The provider's cleanliness and hard work of the housekeeping staff was commented on positively. Patients felt care was individualised and the majority of staff were compassionate. However, some patients felt a change to the shift pattern had a negative impact on the ward, some staff can be inconsistent in their responses to situations, communication amongst staff could improve and more staff were required.
- The provider received an overall rating of five stars on the NHS choice website completed by two participants on the quality of cleanliness, staff co-operation, dignity and respect, involvement in decisions and accommodation.

The involvement of people in the care they receive

- Young people said they were involved in their care plans, they knew most of the staff, received support from an advocate and could give feedback to staff.
- Out of five records reviewed, all patients had received a copy of their care plan and were involved in developing them. There was evidence of family involvement with care plans and risk assessments.
- Young people had access to an advocate and Independent Mental Health Advocate (IMHA).
- Young people completed satisfaction surveys at discharge. Questions surrounded their experience of admission, their stay, discharge, communication and meetings with staff, involvement with their care plans,

Requires improvement

Child and adolescent mental health wards

medication and dignity and respect. Overall results in the last 12 months showed young people were between 81% and 100% satisfied with the service and between 57% and 93% percent happy with the service.
- Patients were involved in recruitment and attended interviews of new staff. In September 2016, two patients were involved in recruitment interviews for four staff for Springfield and the adolescent wards.

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

Good

Access and discharge

- The provider's average bed occupancy for the last six months from 1 March 2016 to 1 September 2016 was 91% for young people on the adolescent ward.
- Care pathways and admissions were from other inpatient units or various parts of the United Kingdom due to placements not being available in their home area to meet their needs.
- Average length of stay for patients at 1 September 2016 was 133 days for young people on the Adolescent ward. According to research from NHS England (2013), 116 days was the average length of stay.
- From 1 January 2016, the provider reported five delayed discharges. Reasons for delays were due to parents being unable to take young people home, inadequate community services for discharge or housing issues
- The provider planned admissions and discharges in advance. Staff said they sometimes received inappropriate referrals, with patients needing a higher level of care than the service could provide. Staff declined the admission of patients when the provider could not meet their needs.

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The facilities promote recovery, comfort, dignity and confidentiality

- Young people on the adolescent ward had their own dining area for meal times.
- The provider had recently built a new clinic room on the adolescent ward
- Young people had their own female and mixed lounge on the ward. The mixed lounge was spacious, comfortable with plenty of seating and a TV. The female lounge was in the process of being completed and was waiting installation of safety glass and a door. However, during our inspection, we observed young people choosing to sit in corridors.
- Visitors used bedrooms for visits or the multi faith room where child visits could also take place.
- Young people had a school on site, which provided up to 25 hours a week of education and developed individual curriculum plans for young people. The school had not yet been inspected by the Office for Standards in Education, Children's Services and Skills (OFSTED).
- Young people had a physical education programme and could access a gym externally.
- Young people had phones in their bedrooms, which they could pay to use when required or they could keep and use their own mobile phones and computers.
- Young people had access to a large enclosed garden for fresh air when required.
- Young people did not have access to keys for their bedrooms but they could lock their doors from the inside.
- Young people had safes in their bedrooms. However, these were not being used for young people to store their personal possessions but rather for staff to secure banned items.
- Young people had access to a kitchen where they could make snacks and have hot drinks all day. Young people used the Lodge weekly for cooking sessions subject to risk assessments with occupational therapy staff.

Meeting the needs of all people who use the service

- Information leaflets were available on request in different languages if required.
- Information on young peoples' rights, treatment, how to complain, advocacy and safeguarding were available.
- Staff had access to interpreters for young people whose first language was not English, to help assess patients' needs and explain their rights, as well as their care and treatment when needed.
- Patients were provided with food to meet dietary requirements and cultural needs. Meal choices included options for gluten free, vegan and halal diets.

Requires improvement

Child and adolescent mental health wards

- There were opportunities to meet patients' cultural, language and religious needs. There was a multi faith room, which could be accessed on the provider site. The provider has a multi faith lead who liaises with local spiritual communities and leaders.

Listening to and learning from concerns and complaints

- The provider had 28 complaints within the last 12 months. However, complaints from the adolescent ward had no trend.
- Eight complaints were upheld or partially upheld.
- The provider received 19 complaints for the adolescent ward in the twelve months to September 2016 and 19 compliments for the Adolescent ward.
- The provider had systems and processes for recording and managing complaints. Outcomes were provided to the staff and young people. Records of complaints including outcome response letters to carers. These were open honest and demonstrated good duty of candour.
- Young people completed discharge questionnaires to provide feedback. The provider carried out annual surveys to gain feedback from patients and family/ friends with action plans to and timeframes to respond to any identified issues.
- Young people had daily community meetings and the senior management team met with patients and young people on a monthly basis for a 'your say forum' where feedback was written and actioned on a 'you say, we did' board. The provider informed young people on actions taken in response to feedback.

Are child and adolescent mental health wards well-led?

Good

Vision and values

- The provider had a clear set of organisational values including putting people first, being a family, acting with integrity, being positive and striving for excellence.
- Staff knew who senior managers were and said they were approachable and visited the provider regularly. The executive team visited each site in August 2015 to present the new purpose and values. Follow up visits took place in April 2016. All staff were invited to attend these roadshows. In addition, the provider supplied a copy of the purpose and behaviours to every employee in the company with their wage slip. Posters were displayed on site, and "credit cards" were available for staff detailing the purpose and expected behaviours. The purpose and expected behaviours had also been integrated into the new Care Certificate workbooks.

Good governance

- The provider used an electronic "dashboard", to monitor quality objectives, human resource information, finance and occupancy. Monthly scorecards were also distributed on mandatory training, incidents, complaints, regulatory issues and medicines.
- The provider had a compliance manager who monitored quality data such as risk assessments and care plans to ensure they were up to date.
- The provider had a learning outcome group where incidents and complaints were reviewed and lessons learnt shared with clinical governance and team meetings.
- Morning flash meetings were held to review the previous day and night where incidents and staffing issues were discussed. These were attended by senior managers, ward managers and staff. Senior manager met weekly in a group and also had individual meetings with the director.
- The provider had systems in place to ensure that staff received regular supervision and support. Supervision data from 1 September 2015 to 1 September 2016 showed a 90% compliance rate, which did not meet the provider's target of 95%. However, we reviewed supervision records on wards and found that staff had access to regular individual or group supervision.
- The provider's risk register highlighted safety concerns, identified actions to resolve these with timeframes for completion. On-going risks were identified.

Leadership, morale and staff engagement

- The top three issues from the results of the staff survey included staff feeling valued in the work they do, staff having the equipment and resources to do the job properly and staff receiving the training and development they need to do the job well. The provider had submitted an action plan with timeframes to address this.

Requires improvement

Child and adolescent mental health wards

- There were no reported bullying and harassment cases and staff said they worked well as a team. Staff knew how to raise concerns if they needed to without fear of victimisation.
- Staff were open and transparent with patients and we saw that duty of candour was exhibited when the service had made mistakes.
- Sickness and absence rates were monitored and managed well.
- There were opportunities for staff to engage in further development, for example leadership courses and further development.
- Most staff reported good multi-disciplinary team (MDT) team working and being able to approach their managers with any concerns or feedback and feeling supported by them.
- There were out of hours on call rotas for senior nurses, managers and doctors who staff could contact to discuss issues with.

Commitment to quality improvement and innovation

- The provider had completed quality improvement objectives for 2016 with actions and targets for future improvements.
- The provider completed quality walk rounds by senior staff, patients and staff walk around to record the quality of the hospital
- Staff, patients and carers were able to nominate staff members for awards where staff were recognised for their contributions to the service at the annual pride awards.
- The provider had received accreditation by the Quality Network for Inpatient Child and Adolescent services (QNIC). The network aims to demonstrate and improve the quality of inpatient child and adolescent psychiatric in-patient care through a system of review against the QNIC service standards. This process follows a clinical audit cycle with self-review and peer-review.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure ligature risk assessments include all ligature points and rate these appropriately.
- The provider must ensure all patients with addictions have drug testing and appropriate assessments to establish withdrawal and inform treatment for detoxification.
- The provider must ensure a specialist doctor is available for patients receiving treatment for addictions.
- The provider must ensure staff receive adequate training to treat patients with addictions.
- The provider must ensure medical equipment does not expire.
- The provider must ensure male visitors are not permitted to enter female ward areas.

Action the provider SHOULD take to improve

- The provider should record the holds staff use when restraining young people.
- The provider should ensure patient paper and electronic records are consistent in content and easy to follow.
- All patients should be offered copies of their care plans to sign and keep records of.
- The provider should ensure young people are able to lock away their personal possessions
- The provider should ensure all changes to rotas are recorded to ensure adequate staffing numbers on wards.

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
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not include all ligature points or rate risks appropriately on their ligature risk assessment.** **The provider did not ensure all patients with addictions had drug testing or appropriate assessments to guide treatment for detoxification.** **The provider did not have a specialist doctor for patients receiving treatment in addictions.** **The provider did not ensure medical equipment was not out of date.** **This was a breach of regulation 12 (1)(2)(a)(b)(c)(g)**

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had not ensured staff received sufficient training to treat patients with addictions.** **This was a breach of Regulation 18(1) (2)(a)**

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The provider had not protected the privacy and dignity of female patients on the acute ward as male visitors entered the female area for visits. This was a breach of Regulation 10(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured robust systems were in place to monitor and treat patients with addictions. This was a breach of Regulation 17(1)(2)(a)