Priory Hospital Burgess Hill

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	Good ●
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive?	Good ●
Are services well-led?	Good ●

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We rated Priory Hospital Burgess Hill as good because:

- The service provided safe care. The ward environments were safe and had enough nurses and doctors. Staff assessed, managed and mitigated risks well. They were actively minimising the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided and developed sufficient action plans to address issues.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that all substantive, bank or locum staff received training, supervision and appraisals. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act. Staff had a good understanding of the Mental Capacity Act.

- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of their patients. They involved patients and families and carers in care decisions.
- The service worked to a recognised treatment model appropriate to the patient group. It was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- On the rehabilitation ward staff were not consistently following the hospital policy for medical monitoring of patients using the ward's seclusion facilities. On one occasion staff had not followed up the physical health concerns of a secluded patient.

- The service had regular medicine errors highlighted by monthly pharmacy audits although there was learning from this and the incidents were reducing. Additionally, medicine labelling and patient information for medicines that patients took when transferred or discharged was not appropriate. Clinic room refrigerators were dirty on Michael Shepherd ward and their cleaning records showed several dates missing within the previous month. Expired medicines were not being disposed of in accordance with hospital policy.

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	**Good** ●	• The service provided safe care. The ward environments were safe and had enough nurses and doctors. Staff assessed, managed and mitigated risks well. They were actively minimising the use of restrictive practices and followed good practice with respect to safeguarding. • Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided and developed sufficient actions plans to address issues. • The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that all substantive, bank or locum staff received training, supervision and appraisals. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare. • Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983. • Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of their patients. They involved patients and families and carers in care decisions. • The service was well led and governance processes ensured that ward procedures ran smoothly. **However:** • The service had regular medicine errors highlighted by monthly pharmacy audits. Additionally, medicine labelling and patient information for medicines that patients took when transferred or discharged was not appropriate.

Summary of findings

Forensic inpatient or secure wards

Good ●

- Staff rarely used physical restraint and seclusion and did so only after verbal de-escalation had proved unsuccessful. Staff participated in the provider's restrictive interventions reduction programme. Staff completed a positive behaviour support plan for each patient, in collaboration with them.
- Patient risk assessments and care plans we reviewed were personalised, holistic and up-to-date. Care plans were recovery oriented and incorporated the strengths and goals of the patient.
- Patients had access to individual and group sessions with the ward psychologist.
- Staff promoted the importance of a healthy lifestyle to patients. Patients had good access to physical healthcare.
- Staff received mandatory training, an annual appraisal and regular supervision sessions. Staff attended regular team meetings, to discuss topics such as safeguarding cases; compliments and complaints; recent incidents; and, staff-related issues. All staff participated in reflective practice sessions, where they could discuss instances of good practice and areas for development.
- Staff treated patients with compassion and kindness and understood the individual needs of each patient. Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Patients had access to general and specific mental health and mental capacity advocacy.
- Staff supported patients to spend time away from the ward and to maintain relationships with their friends and relatives. Staff supported patients during referrals and transfers between services.
- All patients had their own bedroom, with en suite toilet and shower. The ward had a range of rooms available for meetings, therapy sessions, relaxation and activities, including a well-equipped clinic room.
- Leaders had the skills, knowledge and experience to perform their roles and had a thorough understanding of the services they managed. Patients and staff told us that managers were approachable.

Summary of findings

- Staff felt respected, supported and valued. Staff told us the provider promoted equality and diversity within the hospital and said they felt able to raise concerns without fear of retribution.

However:

- The clinic room refrigerators were dirty and their cleaning records showed several dates missing within the previous month.

- Expired medicines were not being disposed of in accordance with hospital policy.

Long stay or rehabilitation mental health wards for working-age adults

Good ●

- The service provided safe care. Staff assessed and managed risk well. They managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice.
- The ward team included the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff were up to date with training and understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Summary of findings

- The service worked to a recognised treatment model appropriate to the patient group. It was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- Staff were not consistently following the hospital policy for medical monitoring of patients using the ward's seclusion facilities. Staff had not followed up the physical health concerns of a secluded patient.
- Patients did not have free access to hot and cold drinks, nor to the ward garden without the assistance of ward staff. Patients wanted more opportunity to prepare their own meals. Areas of the ward needed repair and more regular cleaning.
- The ward garden was small and without seating, and patients could not access it without a staff escort.

Summary of findings

Contents

CareQuality Commission

Good ●

Priory Hospital Burgess HIll

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure wards; Long stay or rehabilitation mental health wards for working-age adults.

Summary of this inspection

Background to Priory Hospital Burgess Hill

The Priory Hospital Burgess Hill is a purpose-built hospital providing acute and psychiatric intensive care units as well as specialist medium and low secure services and long stay rehabilitation services for people with mental health needs. The hospital currently had five wards open which included one male acute ward, one male PICU ward, one female PICU ward, one female low secure forensic ward and one high dependency female rehabilitation ward with a specific 12 month psychologically led programme of treatment for patients with a high acuity of need. One medium secure forensic ward was closed to admissions following a previous serious incident and was undergoing a full refurbishment. The hospital told us that this would not be re-opening as a medium secure ward.

The hospital last had a comprehensive inspection in October 2016, with further follow up visits in June 2017, April 2018 and September 2018.

The most recent inspection was a focused responsive inspection which was carried out in response to CQC receiving concerning information about the service. At that inspection, areas for improvement were identified but no breaches of regulation were found.

The hospital is registered to provide the following regulated activities:

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

There was a registered manager in place at the hospital.

Our inspection team

Our inspection team consisted of four CQC inspectors, one assistant inspector and six specialist advisors with a variety of mental health experiences.

Why we carried out this inspection

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

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?

During the inspection visit, the inspection team:

- visited all five wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 12 patients who were using the service
- spoke with the hospital director
- spoke with the ward manager or acting managers for each of the wards
- spoke with 23 other staff members; including doctors, nurses, occupational therapist, psychologist, pharmacist, health care assistants and domestic staff
- attended and observed two hand-over meetings

Summary of this inspection

- looked at 27 care and treatment records of patients
- carried out a specific check of the medicine management on all wards

- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients were largely positive about the service. Patients reported feeling safe on the wards and respected by staff members. They felt that most staff were supportive and approachable. Patients said they felt involved in decisions regarding their care and confident to raise any concerns.

Patients told us that they were given the opportunity to feedback about the quality of the service on the ward in a variety of ways.

However, patients also stated that they would like to see an improvement to the quality of the food and have more opportunity to cook for themselves. They also felt that there were parts of the ward environment that needed repair which was not happening in a timely way. Additionally, patients felt that they wanted more activities coordinated on the wards.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good 🟢

We rated safe as good because:

- All wards were safe, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. All staff received a personal alarm and the hospital had recently installed a 'pinpoint' alarm system.
- Staff used restraint and seclusion only after attempts at de-escalation had failed. Staff actively participated in the provider's reducing restrictive interventions committee.
- Staff understood how to protect patients from abuse and exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and exploitation and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
- Staff regularly reviewed the effects of medications on each patient's physical health and monitored patients' physical health appropriately.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

However:

- On one occasion we saw that staff were not following the hospital policy and Mental Health Act Code of Practice for medical monitoring of patients using the seclusion facilities. Staff had not followed up physical health concerns of a secluded patient.
- The service had regular medicine errors highlighted by monthly audits. The service did demonstrate an improvement month on month since highlighting and addressing medicine errors. Medicine labelling and patient information for medicines that patients took when transferred or discharged was not

Summary of this inspection

appropriate or complete. The clinic room refrigerators on Michael Shepherd ward were dirty and expired medicines were not being disposed of according to the hospital organisational policy.

- Some wards areas were visibly dirty and ward staff were unaware of the cleaning schedule of domestic staff.

Are services effective?   Good ●

We rated effective as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audits and developed appropriate actions plans from these.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills required to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff and there was a seamless integration between bank or agency staff and substantive staff on the wards.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant services outside of the hospital.
- Staff understood their roles and responsibilities under the Mental Health Act and discharged these well. Managers made sure that staff could explain patients' rights to them. Staff demonstrated sound knowledge of the Mental Capacity Act.

However;

- Staff lacked the confidence to complete mental capacity assessments for patients even if they were the more appropriate person to undertake it.

Are services caring?   Good ●

We rated caring as good because:

Summary of this inspection

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment and condition.
- Staff involved patients in care planning and risk assessment and sought their views on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff suitably informed and involved families and carers of the care and treatment provided to the patient.

Are services responsive?

Good ●

We rated responsive as good because:

- The service managed beds well. This meant that a bed was available when needed and that patients were not moved between wards or hospitals unless this was for their benefit. Discharge was only delayed due to ongoing placement funding difficulties.
- The design, layout, and furnishings of the service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy, phone calls and visits.
- The food was of a good quality and choice and patients could make hot and cold drinks at any time.
- The wards met the needs of all people who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy, cultural and spiritual support. Patients had access to a multi faith room and could visit their chosen place of worship to attend religious services, subject to individual risk assessment.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However;

- On Amy Johnson ward, the outdoor space for patients was of poor quality with no seating or shelter and patients did not have open access to hot and cold drinks on the ward.

Are services well-led?

Good ●

We rated well-led as good because:

Summary of this inspection

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well. All staff received regular supervision and appraisals and mandatory training had a high completion rate.

- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

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.

Mental Health Act training was mandatory for all staff and we saw that attendance was high and that this training was renewed every year.

Consent to treatment was in place for all the patients that we reviewed. Patients confirmed to us that their rights under the Mental Health Act had been explained to them regularly and we saw reminders on the ward manager's dashboard when it was time to renew explanations of patients' rights. Staff had access to support from the Mental Health Act office.

Patients told us that they had access to an independent mental health advocacy service and we saw the contact information displayed on all ward noticeboards.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training was mandatory for all staff and completion rates for this training were high. Staff renewed their training every year.

Staff we spoke with were aware of the principles of the Mental Capacity Act. However, we found that ward staff were not participating in the assessment of patients' capacity and this was left solely to the ward doctors but this didn't directly impact the timeliness of assessments.

We saw that capacity assessments on a decision-specific issues were recorded in care records where appropriate such as managing finances or managing their personal care and that best interests meetings had been held.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Forensic inpatient or secure wards	Good	Good	Good	Good	Good	Good
Long stay or rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

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

Good ●

Safe	**Good**	●
Effective	**Good**	●
Caring	**Good**	●
Responsive	**Good**	●
Well-led	**Good**	●

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

Good ●

Safe and clean environment

Safety of the ward layout

All wards undertook daily risk assessments of the care environment. The nurse in charge undertook four checks a day and appointed security lead for each ward undertook further daily checks.

Security leads were assigned on each shift on all wards and they had a checklist to complete for the ward which included finding, reporting and actioning any environmental risks found. Only staff who were suitably experienced on their ward and competent with the role were assigned.

There were multiple blind spots and ligature risks across the wards. However, the service undertook ligature risk audits and blind spot risk assessments every six months. Each identified risk was mitigated by staff presence, individual risk assessments or building modifications where possible. Staff were present and observing all areas of the ward.

Additionally, the service utilised closed-circuit television called 'care protect' in all public areas and bedrooms where patients consented to this. Otherwise, all bedroom cameras were switched off with a 'hood' placed over them. In addition to footage being shown in the nursing office, an external company employed experienced healthcare professionals to monitor the footage and contact the wards if something of concern was noted. We saw this in action whilst inspecting Edith Cavell ward and staff responded quickly and appropriately. Staff were aware of areas of risk within the wards and ligature cutters were readily available and identifiable around the wards in the event of an emergency.

All staff who joined the service were required to complete ligature audit workbooks to ensure that they fully understood the management of ligature points and the observation policy.

All wards were single sex wards and all patient bedrooms were en-suite with shower rooms.

All staff received a personal alarm and set of keys from reception when signing in to work. There were appropriate systems in place within reception to ensure alarms were charged and working. The majority of ward-based staff also received a radio.

All wards had recently installed a 'pinpoint' alarm system. This system ensured a fast, audible sound was relayed to all wards when a staff alarm was pulled anywhere across the hospital. Display units on multiple sites on each ward clearly displayed where the distress call was coming from and ensured that the assigned responder for each ward could quickly locate the call and attend.

All staff received an appropriate induction and training on security to ensure proper use of alarms and the key system. All rooms had alarms that patients or staff could use to alert staff to any incident.

Maintenance, cleanliness and infection control

Domestic staff were employed by the service and attended the wards daily. However, some ward areas were visibly

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

Good ●

dirty with debris and stains. Additionally, ward teams were unaware of what was due to be cleaned and what had already been cleaned by domestic staff each day. There was a disconnect between ward teams and domestic staff in this regard.

On Wendy Orr ward, domestic staff were given a patient handover and advised to switch their radios onto the same frequency as ward staff to ensure their security whilst working on the ward.

All furnishings were in good working order and appropriate for the wards.

Staff adhered to infection control principles and an infection control audit was conducted monthly by the service.

Seclusion room

Seclusion rooms allowed for clear observations and two-way communications. Each seclusion room had a toilet and shower facilities with an appropriate blind to protect patients dignity. The rooms also had visible clocks.

Nursing reviews of seclusion were carried out by the required two registered nurses. All seclusion paperwork that we viewed was appropriately completed and demonstrated good recording of 15-minute observations, with two hourly reviews undertaken by nursing staff.

Clinic room and equipment

All clinic rooms were fully equipped and had accessible emergency equipment and medicine. All equipment was appropriately calibrated, maintained and portable appliance tested

The service appropriately monitored, recorded and maintained clinic room and fridge temperatures.

Safe staffing

Nursing staff

Each ward was staffed using an agreed staffing ladder that was in place. The staffing ladder calculated the number of staff required based upon patient numbers, acuity and observations, following national guidance on safe staffing. All ward managers had an understanding of the staffing ladder. Staffing levels and the staffing ladder were reviewed by the Priory Group's central team annually to ensure it conformed with national guidance.

The hospital currently had high levels of staff vacancies. As of December 2018, they had a 47% overall vacancy rate. However, the hospital had improved on this at the time of our inspection and had employed a dedicated workforce recruitment lead to drive recruitment and we saw numerous offers in place and staff awaiting final checks to begin employment. Additionally, the hospital managed bank and regular agency staff well to ensure that all shifts were filled and safe staffing levels maintained.

There was a recruitment plan in place that included a range of targeted recruitment campaigns as well as retention and staff wellbeing initiatives for the current workforce.

Each morning there was a hospital-wide handover meeting between ward managers and senior staff to discuss ward business, including staffing levels. Where ward managers required additional staffing to account for escalation of risk on the wards, there was an appropriate procedure in place.

Each day shift ran between 7.30am and 8pm with a minimum of two registered nurses and four healthcare assistants, with each night shift running between 7.30pm and 8am with four members of staff that included at least one registered nurse. The shift pattern in place allowed for a 30-minute handover between shifts.

Bank and agency staff were deployed in the service to maintain safe staffing levels. Where they were used, the service tried to ensure that they were familiar with the ward they were working on and regularly used to ensure continuity of care for the patients.

All bank and agency staff received an induction to the service and had to complete competency checks before being allowed to work on the wards. Additionally, bank and agency staff had to undertake a prevention and management of violence and aggression course before they were permitted to work independently on the wards.

Bank and agency staff had the same access to supervision, training and care records as substantive staff members. The bank and agency staff were fully integrated within ward teams. Staff reported being treated the same as substantive staff and were also given additional roles and responsibilities when necessary to further their development.

There was a regular staff presence across the wards with an effort by staff to keep their time in the nursing office to a minimum to ensure they were interacting with patients.

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

Good 🟢

Medical staff

There was adequate medical cover across the service with dedicated ward consultants and specialty doctors available.

There were appropriate out-of-hours duty systems in place for on-call consultants who stayed in on-site accommodation and on-call managers.

Additionally, the service had a visiting GP who attended weekly and we saw appropriate agreements in place with further external healthcare professionals such as dietitians, tissue viability nurses and dentists.

Mandatory training

The service had an overall compliance rate of mandatory training for all staff of 98%. This exceeded the organisation's target of 92% and included all substantive, locum and bank staff.

The hospital employed a learning and development lead to monitor when training was due and ensure ward staff completed it. Staff received protected time if required in order to complete training and we saw evidence of overtime being paid to staff in order to complete training outside of their normal working hours.

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 17 patient risk assessments and found them all to be present, up to date and thorough, assessing a range of relevant risks. All patients received a risk assessment on admission that was updated at least every week during ward round, or sooner if required.

Staff completed standard risk assessment forms on the electronic care records system that were based upon the five P's model; presenting, predisposing, precipitating, perpetuating and protective. This was to ensure all risks were identified as well as triggers, behaviours and actions to take.

Additionally, patients had positive behaviour support plans in place which listed in a patient's own words what they wished to happen should they become challenging or agitated.

Management of patient risk

Staff demonstrated a good knowledge of their patients and the risks they posed. Management plans were in place for all identified risks in the patient care records we reviewed.

Staff were assigned to different roles for each shift to ensure staff understood their roles that day. These included a security lead, observations lead and rapid response leads.

The service had an observational policy in place that staff were aware of and followed. There was a good staff presence about the wards to minimise risks associated with the ward layouts and we saw staff actively attempting to be as least restrictive as necessary with observations. Decisions of decreasing observation levels were taken by the full multidisciplinary team. All staff completed a competency assessment before undertaking patient observations.

There was a search policy that staff adhered to. The service undertook regular random room searches and more frequent searches based upon intelligence or incidents and events.

Staff applied blanket restrictions on patient's freedom only when justified on the basis of risk. For example, patients were individually risk assessed for certain items on the ward and also for access to areas such as the kitchen.

All ward entrance doors were locked. The doors had clear signs explaining the rights of informal patients to leave. Ward staff told us that if an informal patient wanted to leave the ward they would unlock the doors for them. Where concerns regarding the patient's wellbeing or safety were identified, staff would use their holding powers under the Mental Health Act 1983 and inform a doctor to undertake an immediate mental health assessment for the patient.

The service had a reducing restrictive practices committee that met monthly and we saw positive change towards this on the wards. There were plans to create separate hospital entrances for the acute mental health wards to enable the environment and reception areas to be less restrictive to their patients. The current entrance was based on a more secure hospital design and patients and staff described the delays that this could cause in entering or leaving the site.

The hospital site was smoke-free at the time of the inspection. Patients were informed of this either before or

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

Good 🟢

during admission. The wards encouraged and supported smoking cessation and offered nicotine replacement therapy and/or disposable electronic cigarettes to all patients requiring it.

Use of restrictive interventions

For the six months prior to May 2019, the service reported 71 incidents of seclusion, with Helen Keller ward the highest reporter with 29 incidents of seclusion.

We saw evidence that demonstrated staff followed appropriate procedures during and after seclusion including patient observation, recording, monitoring and de-briefing of staff and patients.

There were 123 incidents of physical restraint over the same period of time. Helen Keller ward had the highest levels of restraint with 85 incidents. Three incidents of restraint on the same ward led to intramuscular rapid tranquilisation being administered. Staff ensured appropriate monitoring of patients following rapid tranquilisation and the service undertook monthly monitoring audits to ensure consistency.

The service reported zero episodes of prone restraint.

The hospital had an active reducing restrictive interventions programme in place and the service demonstrated a reduction in restrictive interventions over the last 12 months.

Each incident of restraint was reviewed by the hospitals prevention and management of violence and aggression trainers to ensure that restraints were appropriate and necessary.

Since the hospital appointed a new hospital director, we saw significant changes in place in an attempt to reduce restrictive practices across the hospital site. There was a reducing restrictive practices committee meeting monthly that fed into overall governance meetings that also had appropriate patient representation. Risk planning, risk management and care planning had recently changed to ensure greater patient involvement in their care alongside positive risk taking to further develop rehabilitation and all wards were taking part in the 'safewards' initiative to improve working relationships and cultures between staff and patients. A working group regularly met to discuss the safewards initiative and its implementation.

Safeguarding

Staff demonstrated a sound knowledge of safeguarding and how to raise a safeguarding alert. All eligible staff had completed the safeguarding adults and safeguarding children mandatory training.

There was a clear safeguarding process in place to aid staff, with a hospital safeguarding lead available for support. Staff were aware that they could raise a safeguarding concern directly with the local authority and recent changes to the safeguarding form explained this and gave direct contact details for the local authority.

The hospital had a safeguarding tracker and discussed open cases, referrals and actions plans at fortnightly safeguarding committees.

There were family rooms and safeguarding procedures in place for when children visited patients. The rooms were off the ward environment and prevented children from having to enter the wards.

Staff access to essential information

The service utilised an electronic patient care records system which most staff could access. Substantive staff, bank and longer-term agency staff all had their own secure login for the system.

Staff told us of their frustrations with the IT systems in place, stating that they often froze and lost unsaved work on the electronic care records systems. We saw evidence that this issue had been escalated to senior management and plans put in place with the Priory IT teams to improve this.

Medicines management

The service appropriately stored and reconciled their medicine. All medicine used on the acute and PICU wards was in date and appropriately labelled.

The service had good links with the local pharmacy team. A pharmacist visited the wards once a week. Regular medicine audits were undertaken by the pharmacy team. Findings from their audits were passed to the consultant for that ward who had to action and respond to the audits via an electronic system. Additionally, we saw discussions around medicines management in clinical governance monthly meetings with the pharmacist attending meetings.

However, there were multiple errors flagged within audits that occurred each month. These included missed medicines, recording omissions and medicine errors. Errors

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

Good ●

were all flagged and appropriately mitigated and managed and we saw that monthly error numbers had reduced since the issue was recognised and addressed by the newly appointed senior management team.

Each ward team appropriately responded to all concerns raised within recent audits and this was an improvement on previous months whereby responses were omitted. This improvement was due to medicines management discussions and action plans being implemented. Staff received supervision around medicines management and repeated competency assessments to refresh their knowledge of the process.

When staff gave patients medicines to take home when discharged or transferred, they were not appropriately labelling patient medicines or supplying sufficient medicine information. We saw standard blank labels supplied by the pharmacy, however staff were not fully completing these to give all information to patients.

An allocated staff member appropriately recorded daily clinic room temperatures and clinic fridge temperatures and detailed actions when this fell out of acceptable ranges.

Staff regularly reviewed the effects of medication on patients' physical health. A suitably experienced member of staff was assigned on each ward as the physical health champion and utilised National Early Warning Score (NEWS) charts to monitor the physical health of every patient daily. We saw appropriate actions taken when the scores from the tests indicated that closer monitoring was required.

Track record on safety

In the previous 12 months, there was one serious incident reported from this core service and related to an infection control incident on Helen Keller ward.

There was a sufficient process in place to ensure that serious incidents were thoroughly investigated and any changes in practice or learning was appropriate disseminated to ward staff.

Reporting incidents and learning from when things go wrong

The service implemented an electronic incident reporting system, IRIS, that all staff had access to and could use to report any incidents. All incidents raised were sent through

to ward managers to review and then to senior management for final sign off. Incident forms clearly detailed immediate actions taken, including any physical interventions. If originally submitted forms were ambiguous or incorrectly filled in, ward managers sent these back to the reporter to amend.

The director of clinical services kept a tracker of ward incidents and identified themes to discuss at clinical governance meetings.

Staff were aware of which types of incidents required reporting and we saw evidence of an array of types of incidents being appropriately reported.

Where changes to practice and learning could be taken from incidents, we saw this disseminated to staff via team meetings, multidisciplinary meetings and learning from bulletins and posters placed on ward office doors.

Staff reported that they received a debrief after serious incidents and that patients also received this support to gain their perspective of incidents.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?
(for example, treatment is effective)

Good ●

Assessment of needs and planning of care

We reviewed 17 care records across the service and each one contained a detailed initial patient assessment. A full range of assessments was undertaken on admission to the service including mental health and physical health examinations by a member of the medical team.

Staff completed initial 72-hour care plans with patients on admission and conducted more thorough care plans once the patient had settled on the ward.

The service recently introduced a care plan approach that agreed holistic care planning with the patients based on four key aspects of their recovery. These included; 'keeping healthy', 'keeping safe', 'keeping connected' and 'keeping well'. Staff commented positively on the implementation of this style of care plan.

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

Good ●

Care plans were personalised, gaining the views of the patient throughout, holistic in nature and goal or recovery orientated. Staff completed thorough care plans and updated them when necessary. Additionally, patients were engaged to create positive behavioural support plans written in their own words to make staff aware of each patient triggers and wishes during challenging circumstances.

Staff clearly documented when care plans were offered to patients and when this was refused.

The service utilised a physical health screening tool called the national early warning score (NEWS). The tool is nationally recognised to support the detection and response to clinical deterioration in physical health of patients. The service regularly audited their NEWS charts to ensure consistency of care and recording. We saw clear actions taken when items were flagged within the audits. There was evidence of regular electrocardiograms and blood tests when required. An electrocardiogram is a test which measures the electrical activity of the heart to show whether it is working normally.

The service had a visiting GP once a week in which there was an appropriate referral process in place to continue physical health screening and monitoring for patients and to refer elsewhere when necessary. The service also employed a full-time practice nurse that was available to support patients with their physical health needs.

Best practice in treatment and care

The service provided a range of care and treatment interventions through psychological intervention, occupational therapy and fitness and wellbeing programmes. These included mindfulness, anxiety groups, anger management and coping skills.

Given the relatively short length of stay, psychology clinics were introduced to the acute mental health wards to provide assessment, formulation and treatment recommendations for patients rather than full psychological therapy provision.

The service recently employed a full-time lead occupational therapist and had worked to fully recruit their occupational therapy team. On inspection, each ward had a dedicated occupational therapy assistant who delivered a timetable of activities Monday to Friday, with nurse-led activities at the weekend. We were told of plans to implement a full seven-day activity programme in the future, once this initial routine had been implemented.

Staff supported patients to lead healthier lives. The service implemented appropriate smoking cessation support, discussed and held groups on healthy eating and could refer onwards for substance misuse issues. The service employed a full-time health and wellbeing lead and patients had access to a dietician.

All wards used Health of the Nation Outcome Scales to indicate if patients' health and wellbeing improved during their admission to the wards

Skilled staff to deliver care

Teams were staffed by a variety of experienced and qualified mental health workers including consultant psychiatrists, specialty doctors, nurses, psychologists, occupational therapists, social workers, health care assistants, a health and wellbeing manager and students or trainees. All staff members reported that they felt well integrated and utilised within the teams. Multidisciplinary team meetings were well attended by a range of health professionals.

Ward managers ensured that all new staff received appropriate inductions and had passed the relevant competency tests before working on the wards. The service implemented a thorough four-week programme of induction for all new substantive staff members that included periods of shadowing, training and supernumerary shifts on the wards.

All staff received regular supervision. Supervision trees were in place for all wards except Wendy Orr, due to recent team changes. All staff including bank and agency staff had access to and were receiving supervision and some wards additionally ran reflective practice group sessions with staff.

All staff were up to date with their yearly appraisals.

The service kept an overall supervision log that was kept up to date by supervisees and collated by the learning and development lead for the hospital to discuss at clinical governance meetings.

All wards held weekly team meetings to discuss business matters on the wards and to raise any concerns.

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

Good ●

The hospital ran monthly staff 'have your say' forums, with staff representatives from across services at the hospital.

There were opportunities for development and training to staff and ward managers ensured staff were given appropriate additional responsibilities on the wards to support this. Training was delivered both internally and externally with some staff members gaining further recognised qualifications.

Ward managers dealt with poor staff performance effectively and fairly. They received support from the central Human Resources department and we saw additional supervision and support put in place for staff members requiring it.

Multi-disciplinary and inter-agency team work

The service held weekly multidisciplinary meetings to discuss each patient on the ward. These were well attended by professionals involved in patient care. All team members reported feeling fully integrated in their teams.

Patients, carers and family members were invited to multidisciplinary meetings and patients reported that they felt listened to in the meetings. The service evidenced that patients received appropriate information about their medicine and treatment.

There were effective handovers between each shift change. The shift patterns allowed for a full 30-minute handover between shifts. Patient risk and status, physical health issues and management of current patient levels of observation alongside recent events and behaviours of the previous shift were discussed. staff demonstrated a thorough understanding of the patients in their care.

Despite many patients being placed at the service a long distance from their home, we saw evidence of good working relationships with patients' local authorities, care coordinators and community mental health teams when necessary. Where there were issues arising from inactivity or uncooperativeness from a patient's local authority to help appropriately move patients on, the service took positive steps to overcome this including raising appropriate safeguarding referrals.

Adherence to the MHA and the MHA Code of Practice

Mental Health Act training had been completed by 98% of staff at the service. Staff demonstrated a good working knowledge of the Mental Health Act, the code of practice and the guiding principles.

All wards had access to a Mental Health Act administrator for support and monitored requirements and compliance with the Act and Code of Practice. Monthly audits and reports were pulled by the Mental Health Act office and sent to ward managers for review.

Patients had clear and easy access to independent mental health advocacy and there were three separate advocacy services that visited the location.

Staff informed patients of their rights on admission and regularly re-informed them thereafter, or after any significant change to their admission and care.

Staff ensured that patients were able to take their section 17 leave from the hospital and there was an appropriate consideration of risk given to this. Before any patient could take their leave, the nurse in charge conducted and signed off a five-point risk assessment of the patient.

Patients' detention paperwork and records were appropriately monitored and stored and copies of them were made available on the electronic care records system for staff to gain access.

Consent to treatment certificates were in place for patients alongside their medicine records. These certificates demonstrated that patients detained under the Mental Health Act had the proper authorisation in in place for their medicine.

Each ward had a clear notice displayed on the ward entrance doors informing informal patients of their rights to leave the ward freely.

Good practice in applying the MCA

All staff at the service had completed Mental Capacity Act training as part of mandatory training. Staff demonstrated a sufficient knowledge of the Act and the five statutory principles.

Deprivation of Liberty Safeguards training was a separate course that had been completed by 99% of staff as part of mandatory training. The service made no Deprivation of Liberty Safeguards applications in the last 12 months.

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

Good ●

Staff could access appropriate Mental Capacity Act policies and guidance via the hospital's shared drive and could request support from the Mental Health Act office if required.

Staff took practical steps to enable patients to understand their care and make their own decisions. This included the use of interpreters and signers for those requiring them.

We saw evidence of discussions and consideration of mental capacity in multidisciplinary case reviews and care records. There was a considered and appropriate approach to patients' capacity.

Where staff suspected patients lacked capacity for specific situations, formal capacity assessments were undertaken and best interest decisions were made following consultation with the relevant people.

However, we found that all capacity assessments were completed by the medical team. Nursing staff told us that they requested capacity assessments from the medical team regardless of what the capacity assessment was for. We didn't see this directly impacting the timeliness of assessments.

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

Good ●

Kindness, privacy, dignity, respect, compassion and support

Staff interacted with patients in a respectful and understanding manner and gave responsive and appropriate help and support to patients when they needed it. Staff spoke of patients in meetings in a kind and compassionate manner and demonstrated a deep understanding of their patients, their risks and wishes.

There was a clear effort by the service and its staff to interact with patients and minimise their time in ward offices.

Patients reported that most staff were helpful, respectful and caring towards their needs and took a genuine interest in their wellbeing.

Staff supported patients to understand and manage their care and treatment. Staff held one-to-ones with patients, supplied patients with information leaflets and responded to queries promptly.

Staff understood and were sensitive to patients personal, cultural or religious needs.

Staff ensured patient information was kept strictly confidential at all times.

Involvement in care

Involvement of patients

Patients who were new to the ward received an orientation from ward staff as part of settling in. If patients were too ill when admitted to the ward, they were later orientated by staff. Patients also received ward welcome booklets which detailed the information about the ward.

There was clear evidence of patient involvement in care planning. Patients' views were included and patients wrote their own positive behaviour support plans. Care plans were signed by patients and it was clearly documented when a care plan was given to a patient or if they refused. Patients reported feeling listened to and were given opportunities to comment on their care in ward rounds.

Each ward held morning planning meetings with patients to discuss the day's events and decide which activities they would like to partake in. There were weekly community meetings held on the wards to discuss further ward wide issues and gave opportunity for patients to have their say on the service.

Patient representatives from the wards were also invited to give the views and opinions of themselves and their peers in monthly clinical governance meetings. Additionally, the hospital had recently introduced a patients' forum that met monthly with the hospital director and senior management team.

Patients had easy access to advocacy service provided by three separate organisations. These were well advertised around the wards and within patient information booklets.

Involvement of families and carers

The service informed and invited family members and carers to patient wards rounds and updated them when changes to patients care or risk occurred.

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

Good ●

Staff informed family members and carers when patients were close to discharge or hospital transfer in order to fully inform and involve them in the process.

There was a carers' forum in place at the hospital that met monthly and a carers' and family members' survey conducted annually.

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

Bed management

Referrals were received and triaged by a central point of contact within the Priory group. The service did not hold any waiting lists and had a target time of one hour to accept or reject referrals made. In the last six months, no patients waited longer than 12 hours to be admitted from the time of acceptance.

For the 12 months prior to 31 December 2018, the service reported an average bed occupancy of 83% and an average length of stay of 36 days.

The service predominantly received patients out of area from their home locations. The service aimed to stabilise patients as efficiently as possible and worked with patients' local care coordinators to repatriate them to services nearer home at the earliest convenience.

A clinical commissioning group within Sussex had recently lifted a patient placement freeze on the service following a positive quality review. It was hoped that this would lead to more appropriate local placements of patients to the service.

Beds were always available for patients returning from leave.

When patients were moved or discharged this was done at an appropriate time of the day. We saw the service and staff actively working to ensure that patients were not moved during the evening or night.

Discharge and transfers of care

In the last 12 months, the service had eight patients whose discharge was delayed. The ward with the highest number of patients whose discharge was delayed was Edith Cavell ward with four.

All patients whose discharge was delayed were due to patients' funding arrangements for appropriate clinical placements elsewhere. We saw the service actively attempting to speed up the process with regular contact with patients' funders and escalating issues where necessary.

The service liaised with patients' funders, care coordinators and local community mental health teams when appropriate to plan for the patients' discharges.

The facilities promote recovery, comfort, dignity and confidentiality

All patients had their own en-suite bedrooms and were risk assessed to receive their own key. For those patients without a key, they could request that staff locked or unlocked their doors.

Additionally, the service recently implemented a 'care protect' CCTV system that patients could consent to being switched on in their rooms. Patients received information on the system and were given the choice to consent to this or not and an appropriate agreement was put in place for those consenting to it.

Patients were permitted to personalise their bedrooms with pictures and photos if they wished.

Patients and staff had access to a full range of rooms and equipment including activity and therapy rooms, clinic rooms, quiet rooms, de-escalation rooms, seclusion rooms, secure outside space, on-site gymnasium and Activities of Daily Living kitchen unit for occupational therapy assessments.

All wards had quiet rooms where patients could meet with visitors and family rooms off the wards where children could visit the service.

Patients were individually risk assessed as to whether they could have their own mobile phones on the ward. Additionally, each ward had a payphone within a private room for patients to use.

Patients had access to hot and cold drinks at all times.

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

Good ●

Meeting the needs of all people who use the service

The service had disabled access to the wards and allocated disabled rooms with wider entrances and wet rooms to allow for wheelchairs.

The service had information leaflets available for patients regarding their treatment and available services. There were display boards around the wards explaining patients' rights, advocacy services, complaints process and treatment.

Information leaflets were only available in English on the wards, however staff explained that they could be ordered in differing languages when necessary.

Patients had a choice of food to meet any dietary requirements and wishes. Patients reported that the food served was generally of a good standard.

Patients were involved in debriefs after events to gain their views and received feedback on the outcomes of any investigations into incident and complaints.

Listening to and learning from concerns and complaints

The service received 27 complaints for the 12 months prior to December 2018. Eight were upheld and seven were partially upheld.

Patients were aware of how to raise concerns and complaints on the wards. There were posters explaining the process around the ward and information in their welcome booklets. We saw staff attempting to resolve matters locally before a complaint was made. Weekly community meetings gave patients a chance to raise their concerns.

Staff knew how to handle complaints. All staff had completed handling complaints mandatory training and complaints were investigated appropriately.

The service undertook quarterly complaints audits to identify themes and to gain patients perspectives on how they felt their complaints were handled

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

Good ●

Leadership

Leaders within the service had a variety of experience, skills and knowledge required to ensure an efficient running of the service.

Leaders had a clear understanding of the service and ward they managed and were visible on the ward. They displayed a good rapport with patients and were approachable to both patients and staff.

All staff were aware of senior leaders within the service and reported feeling confident to approach them directly if concerns arose.

Additional responsibility and leadership development opportunities were afforded to all staff on the wards to aid their development. This contributed to the hospitals wider staff recruitment and retention aims.

Vision and strategy

Staff were aware of the local hospital's aims and development goals but were not aware of the wider Priory group's vision and values. Staff reported a disconnect with the Priory group. However, they were dedicated to their roles within the local hospital.

The hospital's senior leadership team effectively communicated with staff regarding change and their visions for the future. Ward staff praised the efforts of the new members of the senior management team and recognised the positive change they had on the service in a relatively short period of time.

However, staff were unaware of senior leaders external to the hospital.

The service had an active 'have your say' staff forum that met monthly to discuss staff concerns and issues. We saw evidence of discussions within this forum taken into clinical governance meetings and change brought in as a result. Staff told us they felt listened to and confident to give their opinions.

Culture

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

Good ●

Staff reported feeling respected and well supported in their roles. They expressed pride in working at the hospital and with their colleagues, although there was a disconnect with the wider Priory organisation as a whole.

Staff told us that they felt confident and comfortable in raising issues and concerns either within local ward teams or wider senior management without fear of retribution. They were aware of the whistle-blowing process and understood the steps to take if they needed to raise a concern anonymously.

We saw that ward managers dealt with poor staff performance effectively and fairly with the help and support of the human resources team. We saw extra support and supervision in place for those staff requiring it and appropriate disciplinary proceedings in place when necessary.

Staff supervision and appraisals discussed staff career development and plans, and actions were put into place to realise these.

Staff had access to an employee support programme to support their own emotional and mental wellbeing. However, staff we spoke to who had accessed the service reported that it was of very poor standard with one staff explaining that it left them feeling worse.

Governance

There was a clear governance structure in place to ensure that risks and concerns were appropriately raised and acted upon. Staff supervision, appraisals and mandatory training was appropriately monitored and maintained, incidents and complaints were sufficiently investigated and learning was taken.

There were frameworks in place to ensure that ward or service level essential information was shared and discussed with the appropriate teams and people.

There was evidence of learning from incidents, complaints and safeguarding alerts across the service. We saw efficient change in practices and/or environmental improvements when issues had been identified.

The service undertook a range of audits to ensure that quality standards were maintained. Actions following medicines audits had recently improved and there was a decrease in medicine errors since this was a standing agenda item within clinical governance meetings.

Senior management conducted monthly quality walk round visits of the wards and put in actions plans to address any concerns found.

The service suitably informed external partners such as clinical commissioning groups, local authorities and the Care Quality Commission when incidents or events that needed notifying occurred.

Management of risk, issues and performance

There was a hospital-wide risk register in place that listed key risks based upon departments. For example, there were clinical risks, strategic risks, reputational risks and environmental risks. All risks were given an initial risk rating and then a further risk rating after mitigating actions and controls were put in place. After mitigation, no risks remained high on the risk register.

Any concerns raised by staff on inspection matched those on the risk register and were being actively acted upon.

The service had contingency plans in place in case of emergency, for example, through disease outbreak or IT system failures.

Information management

The service could collect quality assurance data from the wards using electronic systems and the inputting of data was not too burdensome to front line staff.

Staff had access to equipment and technology required for their work. Where information technology inefficiencies were noted by the service, we saw improvement plans in place to address this.

Ward managers had easy access to information pertinent to their role. They could access staff supervision and appraisal data, mandatory training data and information on patient care and staffing levels.

Engagement

Staff had access to up-to-date information about the work of the provider through the intranet, bulletins and notices in the ward offices.

Community meetings were held weekly on all wards to allow patients the opportunity to provide feedback on the service and carers and family members were encouraged to give feedback

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

Good ●

The service had patient representatives sit in on and contribute to key senior leadership meetings and had standing agenda items to allow for patient representative items.

Learning, continuous improvement and innovation

The service had a reducing restrictive practices committee with good patient representation to improve on this aspect of care. We saw a positive change and commitment within the service to ensure this occurred across the wards to improve the culture.

The service employed a dedicated learning and development lead to ensure staff development and career aspirations could be achieved. This role fed into the hospital's overall recruitment and retention programme.

Forensic inpatient or secure wards

Good 🟢

Safe	**Good**	🟢
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Good**	🟢

Are forensic inpatient or secure wards safe?

Good 🟢

Safe and clean environment

Safety of the ward layout

Each patient had their own bedroom with en-suite shower and toilet.

Staff conducted regular risk assessments of the care environment. The ward had a daily allocated security staff member who completed an environmental checklist. The ward manager completed weekly ligature and environmental audits.

The provider had installed convex mirrors to improve sight lines along corridors to reduce the risk of blind spots. Staff were always present on the corridors and had a closed-circuit television (CCTV) system in place. The CCTV system was monitored by an external agency but staff had access to the video feed in the nursing station. Staff could access recordings when needed. For example, staff used recordings during investigations of incidents and complaints. Patients were aware that CCTV was in use. Patients had signed a form to confirm they were aware that CCTV recordings were being made. CCTV was in place in all the bedrooms, however these were covered up and switched off unless formal consent had been given by the patient.

The ward had a very thorough ligature assessment that included all ward areas. Risks to the patient were managed through individual risk assessments and the use of staff observation. The ward had a useful one-page diagrammatic summary which was on display in the nursing office. This showed the location of high-risk areas and the location of two sets of ligature cutters. Staff were confident in identifying ligature risks and knowing where to access ligature cutters when needed.

Staff carried personal alarms with them at all times around the hospital, which they received from the reception at the start of their shift. Wall mounted nurse call systems were mounted in each bedroom, with an additional alarm in all en-suites. There were also additional alarms in the communal bathroom and kitchen.

Maintenance, cleanliness and infection control

Although the ward environment was looking tired, all the ward areas were visibly clean and tidy. On the day of our inspection, the communal areas were being repainted. Staff told us that a refurbishment programme was taking place throughout the hospital. However, staff were unaware of the time frame for this.

Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. We observed housekeeping staff cleaning the ward areas.

There were handwashing signs and facilities appropriately placed around the ward.

Seclusion room

Michael Shepherd ward did not have use of its own seclusion room. The two closest seclusion rooms had been decommissioned as the service had declared them not fit for purpose. The ward had use of two further seclusion rooms. One seclusion room was located through a disused ward on the first floor. The second seclusion room was located on the ground floor, on a male acute ward. Staff

Forensic inpatient or secure wards

were therefore potentially required to escort patients being manually restrained through several doors and down a flight of stairs in order to access the seclusion suite. The hospital had considered the best way to manage any such patient transfers in the best and safest way for both staff and patients. The hospital had a procedure in place for when female patients had to use the male seclusion room. Staff would telephone the ward in advance and use a separate corridor from the male ward to escort female patients to the seclusion room.

Seclusion rooms allowed clear observation and two-way communication and a visible clock. There was an en-suite toilet and shower in both seclusion suites. The toilet in the male ward seclusion suite was situated so that it was in direct view of the staff viewing window, which potentially impaired the privacy and dignity of the occupant. However, the window had a privacy blind that the staff could operate to mitigate against any potential distress.

Clinic room and equipment

Staff stored medicines securely. Records were made of medicine refrigerator and room temperatures on a daily basis and these were all within the expected temperature ranges. Staff were confident in applying the policy and procedure in place for when temperatures were above safe limits.

A pharmacy service was provided by an external contractor. The pharmacist provided an audit check of the medicines fridge temperature checks.

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs. Records showed that staff were regularly checking clinic room equipment. The contents of the emergency medicine bags were checked regularly by hospital staff; all contents were found to be in date.

On the day of our inspection the clinic room fridge was dirty. However, this was rectified immediately by a member of staff. Cleaning records showed several dates missing within the previous month and there was no record of clinic room cleaning audits.

Safe staffing

Managers had calculated the number and grade of nurses and healthcare assistants required for each shift. The ward had a capacity of 16 patients, with seven admitted at the time of our inspection. The daily staffing rota was divided into a day and a night shift. Managers had calculated that two nurses and four healthcare assistants were required during the day and one nurse and four healthcare assistants at night. The ward manager could adjust staffing levels daily to take account of case mix and enhanced observation.

The ward staff team had vacancies for two healthcare assistant vacancies, three band five nurses and one band six nurse. Managers appointed locum staff to provide the best possible continuity of care to patients, pending recruitment of permanent staff. Managers deployed bank and agency staff to fill ad hoc shifts as needed, to maintain safe staffing levels. The hospital prioritised the use of known bank and locum staff to maintain consistency and familiarity with the patients. Bank and agency staff received a thorough induction to the ward. This induction was recorded and signed by both the agency staff member and nurse in charge.

The provider was actively trying to recruit new staff. They advertised at local petrol stations and shops; attended job fairs; and, engaged with universities.

A qualified nurse was present in communal areas of the ward at all times.

Staffing levels allowed patients to have regular one-to-one time with their named nurse. The ward manager tracked this through regular clinical audits. None of the patients we spoke with raised concerns about the availability of staff.

Patients and a carer we spoke with stated that staff shortages rarely resulted in staff cancelling escorted leave or ward activities.

There were enough staff to carry out physical interventions safely and staff felt supported to bring in more staff when needed.

Medical staff

There was good medical cover day and night. A doctor could attend the ward quickly in an emergency. A forensic psychiatrist for the ward provided medical cover between 9am and 5pm from Monday to Friday. Outside these hours, a duty doctor was available. This doctor was based on site.

Mandatory training

All mandatory training had been completed by at least 93% of staff throughout the hospital.

Forensic inpatient or secure wards

Assessing and managing risk to patients and staff

Assessment of patient risk

The inspection team looked at the care records for five patients. Staff conducted a thorough risk assessment of every patient on admission and updated it regularly, including after any incident. Staff used the recognised risk assessment tool, Short Term Assessment of Risk and Treatability, known as START. All five care records were thorough and up to date. Each patient had a positive behaviour support (PBS) plan in place, that clearly identified triggers and behaviours and how these could be managed by staff. Staff worked with patients in a therapeutic way to help them understand and manage their risks. In addition, the service completed, or updated a historical clinical risk management assessment, known as an HCR-20, in the first three months of admission. The HCR-20 form documents the patient's forensic history in detail. The service updated this assessment every six months

Management of patient risk

Staff followed the hospital's policy on observations. Staff used four levels of observation ranging from observing patients every 15 minutes to two nurses being with the patient at all times. Staff reviewed observation levels at handovers and in multidisciplinary team meetings. Staff could only reduce the level of observation after a review by a doctor. The service did not permit patients to have items that could cause harm such as sharp objects, drugs, alcohol or cigarette lighters. Staff searched each patient's property when they were admitted to the hospital and when they returned from leave.

Staff applied restrictions on patients' freedom only when justified. Staff told us they had to switch off the hot water to make hot drinks due to the risk posed by an individual patient. Therefore, patients had to ask staff for access to the kitchen or ask the staff member to make them a drink, depending on their individual risk.

Use of restrictive interventions

There were 10 episodes of seclusion in the six months prior to our inspection. These episodes involved four patients. There had been no episodes of seclusion since February 2019. Staff used seclusion appropriately. Nurses carried out appropriate reviews and staff observed patients at appropriate intervals in line with the provider's policy.

There were no reported episodes of long-term segregation for this ward in the past 12 months.

There were 10 instances of the administration of rapid tranquilisation in the past 12 months. The National Institute for Health and Care Excellence (NICE) defines rapid tranquilisation as 'use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed'. We reviewed six records where patients had been administered rapid tranquilisation. All records followed established national guidance.

There were 14 episodes of restraint in the past four months. These episodes of restraint involved five patients. Staff used positive behaviour support plans to understand how each patient would prefer to be restrained, if needed. Staff told us they used restraint only as a last resort when verbal de-escalation techniques had failed to calm the patient sufficiently. The Priory Group operated a policy of not using prone (face down) restraint.

The ward participated in the provider's restrictive interventions reduction programme. Patients had free access to cold water, bedrooms, bathrooms. Patients had to seek staff support to use the communal kitchen for hot drinks, garden and activities rooms.

Safeguarding

We saw evidence that staff made safeguarding referrals to the local authority and could explain how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff had a good understanding of how to identify adults and children at risk of, or suffering, significant harm. They informed us that they had a good relationship with the local authority and safeguarding referrals were always made quickly and appropriately. Staff could access support from the on-site social worker if needed.

Staff followed safe procedures for children visiting the hospital. Children were not allowed on Michael Shepherd ward. If children visited the hospital, a private family room by the hospital reception, was used.

Staff access to essential information

Forensic inpatient or secure wards

Staff had access to electronic records throughout the hospital, using a system called Carenotes. This information was available to all members of staff, including agency and bank members who had completed their induction.

Medicines management

The provider had an appropriate medicines management policy, which incorporated ordering, storing, administering and destroying medicines. We reviewed the medicines administration charts for all patients on Michael Shepherd ward. We found that staff kept accurate records of the treatment patients received.

Stock medications were shared between wards within the hospital. This included named patient medicine from a ward that had closed. Expired medicines were not being disposed of in accordance with hospital policy. This meant that stock levels were exceeding a six-week supply.

Staff reviewed the effects of medicines on patients' physical health regularly and in line with NICE guidance. For example, patients with diabetes had their blood sugar levels checked regularly and this was appropriately recorded.

Track record on safety

There were 10 serious incidents in the past 12 months. All incidents were investigated thoroughly by the hospital.

Reporting incidents and learning from when things go wrong

Staff we spoke with were confident in reporting incidents using the electronic system.

Staff told us that information was discussed at ward level in the staff communication book, through individual supervision and at staff meetings when serious incidents occurred across the hospital. Staff met for a reflective practice session once a month, led by the ward's trainee forensic psychologist. Learning from incidents across this and other Priory hospitals was shared with staff via a monthly bulletin from the hospital director.

Staff told us that they received a debrief after every incident and had multiple opportunities to discuss incidents. The ward manager highlighted the need for staff involved in the incidents to be present at the debrief and reflective practice and arranged multiple debrief sessions to accommodate all staff.

Are forensic inpatient or secure wards effective?
(for example, treatment is effective)

Good ●

Assessment of needs and planning of care

We reviewed the care records for five patients. Staff had devised patient care plans to meet the needs identified during assessment.

The care plans we looked at were personalised, holistic and recovery oriented, incorporating patients' strengths and goals.

Staff updated care plans when necessary.

Staff completed comprehensive mental and physical health assessments of each patient in a timely manner after admission.

Best practice in treatment and care

Patients had access to a range of psychological therapies that were delivered in line with guidance from the National Institute for Health and Care Excellence. The psychology team individually assessed each patient and formulated their personalised therapeutic plan. Patients had access to individual and group sessions, such as dialectical behaviour therapy (DBT); 'hearing voices'; and, 'boundaries and self-harm'.

Patients had good access to physical healthcare. A GP spent one day each week at the hospital and there was a physical health lead nurse available within the hospital. The ward had good links with their local general hospitals. Patients had access to chiropody and dental appointments as needed.

Staff used Health of the Nation Outcome Scales to measure the health and social functioning of patients on the wards.

The provider operated a smoke-free environment and staff supported patients with nicotine replacement therapy.

Staff promoted the importance of a healthy lifestyle to patients. Staff encouraged patients to make healthy dietary choices and partake in physical activity.

Forensic inpatient or secure wards

Staff participated in clinical audits, benchmarking and quality improvement initiatives.

Skilled staff to deliver care

All non-medical staff on Michael Shepherd ward had received an appraisal as at 30 April 2019.

Medical staff had completed their revalidation process.

The provider's target for clinical supervision was for each member of staff to receive a monthly supervision session. During each of the six months within the period October 2018 to March 2019, over 90% of planned sessions were delivered.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group.

The ward team had access to a comprehensive range of specialists required to meet the needs of patients. As well as a consultant forensic psychiatrist and nurses, the multidisciplinary team comprised occupational therapy, psychology and social work staff. A pharmacist visited the ward each week and other health professionals, such as speech and language therapists, dieticians and physiotherapists were available as needed.

All staff participated in reflective practice sessions, where they could discuss instances of good practice and areas for development.

Staff held regular team meetings. Minutes for the meetings were recorded and accessible to all staff.

Staff we spoke with felt that managers supported them to access training appropriate to their current role and to support their continual professional development.

New members of staff received a corporate induction from the provider and a ward-based induction from the ward manager.

Managers dealt with poor staff performance promptly and effectively.

Multi-disciplinary and interagency team work

Staff attended a handover session when commencing their shift.

Representatives from the ward staff team attended a daily hospital-wide morning meeting. Topics discussed at the meeting included recent incidents, staffing levels and staff-related issues; and, key events for that day.

Staff and patients from the ward attended a joint daily planning meeting five days per week (Monday to Friday).

Staff attended a monthly multidisciplinary business meeting, at which they discussed topics such as safeguarding cases; compliments and complaints; recent incidents; and, staff-related issues.

Staff on Michael Shepherd ward had effective working relationships with staff on other wards within the hospital; senior managers; multidisciplinary clinical and medical staff; and; support staff.

Staff reported having effective working relationships with external teams such as social services, plus local advocacy services and health professionals.

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

The provider submitted training compliance data prior to our inspection. They stated that 98% of staff had completed training in the Mental Health Act.

Staff we spoke with had an appropriate level of understanding of the Mental Health Act, the Code of Practice and the guiding principles in respect to their individual role within the organisation.

Staff had access to policies and procedures on the application of the Mental Health Act. Staff also had access to appropriate administrative support and legal advice from a central team within the hospital. The Mental Health Act administrative team contacted ward staff to remind them of important events, for example when a patient's period of detention was nearing its end.

Patients could request specialist independent mental health advocacy as desired. There was information displayed within the ward on how to contact the advocacy service.

In general, staff ensured that patients could take their allotted section 17 leave (permission for patients to leave hospital) as arranged. Sometimes staff needed to move the time or shorten the duration of escorted leave, due to time pressures within the ward, but they did this in consultation with the patient concerned.

Forensic inpatient or secure wards

Good ●

Staff requested the input of a second opinion appointed doctor when necessary.

We reviewed Mental Health Act paperwork for patients on all wards and found them to be in order and stored so they were accessible to staff who required them.

We saw evidence that staff explained patients' rights to them at the point of admission and at regular intervals thereafter.

Staff carried out regular audits of Mental Health Act documentation.

Good practice in applying the Mental Capacity Act

The provider submitted training compliance data prior to our inspection. They stated that all staff had completed training in the Mental Capacity Act.

Staff we spoke with had an appreciation of the Mental Capacity Act and its five statutory principles.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff we spoke with were aware of the policy and had access to it. They knew where to obtain advice on the application of the Mental Capacity Act, including Deprivation of Liberty Safeguards.

Staff assessed patients' capacity to consent to treatment during multidisciplinary meetings. Capacity and consent were recorded appropriately in the care records we reviewed.

Are forensic inpatient or secure wards caring?

Good ●

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Patients told us that staff were always around to talk to and staff would make time for them. Patients told us that staff were kind and respectful.

It was clear, from our observations that staff had a good rapport with patients. Staff supported patients to understand and manage their care, treatment or condition.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Staff spoke about patients in a respectful manner and maintained their confidentiality at all times.

Staff and patients said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Involvement in care

Staff used the admission process to inform and orient patients to the ward and to the service. Staff told us that they prioritised showing the patient to their bedroom and making sure the patient had food and drink. Introduction to the ward was done at the patient's preferred pace.

Patients said that they were given advice about the treatments available to them and these were regularly revisited.

Care plans and risk assessments were written in a way that was personal to the patient and most incorporated the patient's own views. Patients told us that staff talked to them regularly about their care plans and that staff offered them a copy. Patients were involved in their ward round and review meetings.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Staff could access leaflets and information in easy read format and in different languages. The hospital organised interpreters and signers when needed.

Patients were able to give feedback on the service at the morning ward meeting and at the weekly community meeting. The occupational therapist regularly asked for feedback about the ward timetable, so that it catered to the patients' hobbies and needs. In January 2019, a monthly patients' forum was introduced. Patients could also attend hospital-wide reducing restrictive practice meetings. This had led to patients on Michael Shepherd ward having access to mobile phones, following individual risk assessment.

Forensic inpatient or secure wards

Staff had access to a general advocate, independent mental health advocate and an independent mental capacity advocate. Patients were all aware of the types of advocacy available to them and staff regularly contacted advocates on the patients' behalf.

Involvement of families and carers

Families and carers could be involved in patients' care if the patient wanted this. The service provided patients with leave from the ward to maintain contact with their families.

Families and carers were invited to patients' reviews if consent had been given by the patient.

Families and carers were notified after incidents had occurred.

in the care records we reviewed.

Are forensic inpatient or secure wards responsive to people's needs?
(for example, to feedback?)

Good ●

Access and discharge

Bed management

The provider reported that the average bed occupancy rate on Michael Shepherd ward during the period April 2018 to March 2019 was 43%.

The provider did not supply data for the average length of stay for patients on Michael Shepherd ward.

The provider reported that there were four out of area placements on Michael Shepherd ward during the period April 2018 to March 2019.

Patients' bedrooms were kept available for them when they were on leave.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. The medium secure ward at the hospital had closed for refurbishment in 2018. Four patients from the medium secure ward were transferred to Michael Shepherd ward, as they were deemed appropriate for the low secure setting.

Discharge and transfers of care

The provider reported that there were four delayed discharges from Michael Shepherd ward during the period April 2018 to March 2019.

Staff told us that the main causes of delayed discharge were awaiting confirmation of either the funding for the ongoing placement, or the ongoing package of care.

Staff supported patients during referrals and transfers between services.

Facilities that promote comfort, dignity and privacy

All patients had their own single bedroom and so were not expected to share with other patients.

All bedrooms had an en-suite toilet and shower. There were also communal toilets and a communal bathroom on the ward.

Patients could personalise their bedroom with pictures and items of their choice.

Patients had a lockable space in their bedroom. Staff securely stored the key for each patient locker in the ward office.

Patients could access their bedroom during the day. Patients were given their own bedroom key in line with individual risk assessment.

The ward had a well-equipped clinic room that was large enough to enable staff to conduct physical examinations on patients.

Patients had access to their own mobile telephone in line with individual risk assessment. Staff stored mobile telephone chargers in the ward office and charged patient telephones on their behalf. The ward also had a fixed telephone for patient use.

The ward had its own enclosed garden. Staff supervised all patient access to the garden. Patients accessed the garden via a set of stairs, from the ward on the first floor. Patients who were unable to negotiate the stairs to the garden could use the hospital's central courtyard garden, which they accessed by lift.

The ward had a range of rooms available for meetings, therapy sessions, relaxation and activities.

Forensic inpatient or secure wards

Good ●

The ward had a quiet space for patients to meet with visitors. However, patients often met with their visitors in a room near the hospital's main reception.

Patients we spoke with had mixed views on the quality and choices of food on offer. One patient was generally happy with the food but stated that some meals were unhealthy. Another patient told us the food did not taste good.

Patients could make hot or cold drinks and access a snack at any time of day or night. However, at the time of our inspection, patients had to ask staff for a hot drink, as a result of the individual risk assessment of one patient.

Patients' engagement with the wider community

Staff supported patients to have escorted and unescorted leave from the ward when appropriate, to ensure they developed and maintained relationships with other services and their friends and relatives.

Staff supported patients and carers, to organise family visits to the hospital. Staff provided emotional support to patients both before and after visits, as needed.

Patients had access to education through the hospital's recovery college. Priory Hospital Burgess Hill was an approved Oxford Cambridge & Royal Society of Arts (OCR) examination board, enabling patients to gain recognised qualifications in mathematics and English.

Meeting the needs of all people who use the service

The internal environment within the ward had level access and was therefore suitable for people with restricted mobility.

The ward had one bedroom that was set aside for patients with restricted mobility. Every bedroom had an en-suite shower and toilet.

Patients could use a multi-faith room located just outside the ward. Patients could visit their chosen place of worship to attend religious services, subject to individual risk assessment. Patients could access spiritual support from different religions and faiths upon request.

Staff could access interpreters as needed and could arrange for information leaflets to be translated into different languages upon request.

Patients had the choice of eating food from different cultures and could select meals that met specific dietary requirements.

Information on a variety of topics was available to patients, from details of how to complain or give feedback; how to access advocacy support; contact details for other local agencies; and information on physical and mental health issues and treatments.

Listening to and learning from concerns and complaints

According to the provider, Michael Shepherd ward received one complaint during the 12-month period January to December 2018. The complaint was partially upheld.

The ward received a total of seven compliments during the 12-month period January to December 2018.

Staff displayed information about the complaints process within the ward. Patients we spoke with knew how to make a complaint and did not express any concerns about how staff followed the complaints process.

A carer we spoke with was happy with the feedback they received. They told us that staff had been open and honest in relation to the issue.

Staff we spoke with were familiar with the complaints process and they told us they discussed the outcome of complaints during team meetings, to learn from any mistakes that had been made. Staff were happy with the level of feedback they received from complaints.

Are forensic inpatient or secure wards well-led?

Good ●

Leadership

The ward manager had the skills, knowledge and experience to perform their role effectively. Most of the senior management team had been recently appointed, but showed a clear understanding of the service, had the experience to deliver good quality care and were an enthusiastic team.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Team leaders and senior management had daily meetings to discuss the day's running of wards and a clinical governance meeting monthly to discuss clinical risk.

Forensic inpatient or secure wards

The ward manager was a visible presence on the ward and had a good rapport with patients and staff. Staff felt supported by the ward manager, hospital senior managers and the wider multidisciplinary team. The senior management team completed an environment quality walk round once a month and made themselves known to patients and staff.

Development opportunities were available for staff and goals were identified within supervision sessions.

Vision and strategy

Staff were familiar with the provider's vision and values of putting safety first, putting the patients at the centre of everything they do, taking pride in their work and celebrating success and valuing staff. The hospital has a bi-monthly employee award that rewarded staff for delivering these vision and values.

Staff had the opportunity to contribute to discussions about the strategy for their service through the staff forum run by the hospital director. Staff could also anonymously give feedback through yearly staff surveys.

Culture

Staff we spoke with felt respected, supported and valued.

Staff felt positive and proud about working for the provider and their team. It was acknowledged that staff were anxious about low patient levels on the ward and how this would impact on staffing levels. The management team were reassuring staff to alleviate anxiety.

Staff felt confident in how to use the whistleblowing process. Staff felt able to raise concerns without fear of victimisation. None of the staff we interviewed raised concerns about bullying or harassment.

Managers dealt with poor staff performance promptly and efficiently.

Teams worked well together and staff were able to support across the site, when needed.

All staff had annual appraisals and monthly supervision. Staff could increase the level of supervision on a case by case basis, to offer extra support.

Governance

The service had robust systems in place to ensure that managers had access to information pertinent to their roles. The service had oversight of supervision and appraisals, beds were managed well and incidents, safeguarding concerns and complaints were appropriately logged, investigated and learned from.

The service used an electronic dashboard, which was used to monitor quality objectives, human resources information, financial data and occupancy levels. Senior managers all had access to the dashboard to ensure compliance. A monthly score card was sent to the hospital for mandatory training, incidents, complaints and medicines, so that staff could take action if areas for improvement were identified.

Management of risk, issues and performance

The hospital had a site-wide risk register. Staff reported that they could easily escalate any issues to service leads if required which could then be put onto the risk register.

The risk register contained entries relating to staff concerns and the areas of risk described by senior staff.

The service had a contingency plan in place to ensure continuity of service if there was an emergency effecting service delivery.

Information management

Staff had access to sufficient equipment and information technology in order to do their work. The secure record keeping system was easily available to staff to update patient care records and review, during ward rounds and other team meetings.

Closed-circuit television was in operation in the communal areas of the ward. This aided incident investigations as managers could request to view footage. Managers were able to have oversight of incidents and could develop learning from this.

The care records system was shared hospital wide and held confidentially on systems that only staff had access to with a secure username and password. This eased information sharing between wards and teams.

Team managers had systems and dashboards in place to support them in their role. This included information on staffing, supervision and appraisals, training and service performance data.

Forensic inpatient or secure wards

Staff made notifications to external bodies, such as the Care Quality Commission, police and local safeguarding authority as needed.

Engagement

Staff and patients were kept up to date with service information through weekly bulletins, newsletters, staff intranet, team meetings and community meetings in addition to the service website.

Directorate leaders engaged with external stakeholders such as commissioners, Healthwatch and NHS England.

Learning, continuous improvement and innovation

The ward participated in the safe wards scheme and were working towards implementing all aspects of the programme.

Long stay or rehabilitation mental health wards for working age adults

Good 🟢

Safe	**Requires improvement** 🟠
Effective	**Good** 🟢
Caring	**Good** 🟢
Responsive	**Good** 🟢
Well-led	**Good** 🟢

Are long stay or rehabilitation mental health wards for working-age adults safe?

Requires improvement 🟠

Safe and clean environment

The ward was on the first floor of the hospital building and had 13 patient bedrooms although at the time of inspection the ward was capped at a maximum of ten patients.

Staff had a clear line of sight from the nurse's office to the main ward lounge and dining area. There was good use of convex mirrors to ensure that nurses could view areas of the ward not in direct line of sight.

The ward had closed circuit television cameras (CCTV) in the communal areas and this had a live stream in the nurse's office. Following an incident, staff could request CCTV of the ward events from an external company who stored the recordings. There were cameras in the patient bedrooms which were activated only with the consent of the individual patient. At the time of the inspection no patient had given consent for these cameras to be switched on.

The bedrooms were located on two wings of the ward. All rooms had en-suite shower rooms and had a range of anti-ligature fittings including the bathroom fittings. Bedroom doors had viewing panels which the patient and staff could control. These gave patients privacy but also allowed staff to carry out patient observations. All patients had a key to their room.

All patient areas had been assessed by staff for ligature risks and staff were aware of the location of high-risk areas. The most recent ligature audit had been completed on 18 January 2019.

There was a kitchen on the ward where patients could make hot or cold drinks. The kitchen was locked and patients needed a member of staff to unlock the kitchen and remain with them while they made a drink.

There was a regular housekeeping schedule in place and we saw routine cleaning happening during our inspection. However, areas of the ward flooring were stained, and there were crumbs and food debris on the kitchen floor, work surfaces and toaster. The dining room did not have a curtain on the window as the previous curtain had not been replaced and there were areas of plaster on the walls that needed filling and redecorating.

All staff carried an alarm and there were call buttons in the communal areas and bedrooms for patients and staff to alert if there was an emergency or if they needed assistance.

The ward had a clinic room which was clean and well organised. However, the clinic room fridge lacked adequate shelving which meant that staff were unable to keep medicines in an ordered way and the clinic room bin did not operate via a foot pedal which was a risk to cross-contamination from staff handling the bin lid. We informed ward staff of these issues at the time of inspection.

The ward had access to two seclusion facilities which were located on two other wards at the hospital. Patients requiring seclusion were transferred to these facilities by staff. Staff demonstrated how this was done safely and

preserving the dignity of the patient during the move from one ward to another. The rooms allowed good levels of patient observation and had a two-way communication system for patients to speak with nursing staff.

We reviewed the recent seclusion records for the ward. We found on one occasion that the ward staff had not followed the hospital policy in relation to the frequency and timing of medical checks for a secluded patient and had not taken sufficient actions to follow up physical health concerns for that patient. The hospital policy stated that patients in seclusion should be reviewed by a doctor at the first hour, then subsequently every four hours until reviewed by the multidisciplinary team.

On the first episode of seclusion the patient received a medical review after one hour. However, all subsequent reviews were omitted. Whilst still in seclusion, the patient reported feeling unwell and following an abnormal electrocardiogram (ECG) reading, they were taken to the local general hospital for assessment. However, the patient absconded before this assessment and they were returned to the ward seclusion facility by ward staff. They were reviewed by the doctor within two hours of the commencement of this episode of seclusion. No further medical reviews were undertaken by hospital doctors and the patient did not receive further assessment or monitoring in light of the previous abnormal ECG reading. We brought this to the attention of the hospital managers at the time of inspection.

Safe staffing

There was a two-shift pattern on the ward. The day staff worked a 7.30am to 8pm shift and the night shift was 7.30pm to 8am. This allowed staff a half-hour period for a shift handover. The regular staffing numbers were two qualified nurses and two health care assistants in the day time and one registered nurse and two health care assistants at night. We reviewed the ward roster and saw that these staffing ratios were being met.

There were significant vacancies for registered nursing staff. The ward had a whole time equivalent of 5.7 registered mental health nurses (RMNs) of which 2.2 were filled with permanent employees. The ward filled the vacant hours with regular locum agency staff who had been working at the hospital for some time and had good knowledge of the patients. There were no vacancies for health care assistants at the time of inspection.

All bank and agency staff received an induction to the service and had to complete competency checks before being allowed to work on the wards. The agency staff received regular supervision from the ward manager.

The ward manager used a staffing ladder set by the provider. This tool calculated the number of staff required based upon patient numbers, acuity and observations, following national guidance on safe staffing. The maximum day time staffing when the ward had a full complement of patients was two nurses and two health care assistants. Staff said that they could request additional staffing when there were additional demands such as for escorted leave for patients or a higher level of enhanced observations. Staff and patients commented that at times the staffing levels were not sufficient to meet all the ward activities which meant that patients were waiting for staff to be available to have access to locked areas of the ward, and the garden area.

The medical cover was provided by a full-time consultant psychiatrist based on the ward. The staff we spoke with said that support from the consultant was readily available and the doctor was very responsive and helpful when patients and staff needed them.

Staff sickness rates at the hospital were low at 2.4%. The ward had one long term staff sickness which was being managed via the provider's sickness policy.

Staff received mandatory training and completion was monitored on a central record. At the time of inspection completion rates for training were good at over 95%. Mandatory training included courses covering infection control, safeguarding, basic life support, safe handling of medicines and fire safety.

Staff working on the wards had also completed training in the prevention and management of violence and aggression and also techniques to support positive behaviours. This meant that they learned to keep themselves and patients safe if they were involved in an incident on the ward.

Assessing and managing risk to patients and staff

We reviewed six sets of care records for patients from both wards. There was evidence in all records that risk screening

Long stay or rehabilitation mental health wards for working age adults

had taken place. The clinical staff assessed risks using the tool embedded in the patient's electronic clinical record. This covered five risk areas: presenting, predisposing, precipitating, perpetuating and protective.

Ward staff completed a risk assessment for all patients at the point of admission and then at regular multidisciplinary team reviews and following any significant event. All patients had a detailed risk assessment in place and we saw that this was being reviewed by staff at regular intervals.

Ward staff told us that they had been working to improve the quality of the patient risk assessments. The risk management plans that we reviewed were comprehensive and included the involvement of the patient in their formulation.

All patients had positive behaviour plans. These were individualised care plans to support patients who have, or may be at risk of developing, behaviours that challenge. These were person-centred and had clear records of when the plan was reviewed and amended. Staff were trained in the completion and review of the plans.

Staff we spoke with were knowledgeable about anticipating, de-escalating and managing challenging behaviours and relational security. Staff were up to date with training in recognising and de-escalating aggressive situations which included the prevention and management of violence and aggression (PMVA), and training in positive behaviour support.

We saw that staff were completing and recording regular observations of patients following the hospital policy. These were carried at levels set by the hospital doctor and reviewed by the multidisciplinary team. Decisions of decreasing observation levels were taken by the full multidisciplinary team. All staff completed a competency assessment before undertaking patient observations.

The service had a reducing restrictive practices committee that met monthly and we saw positive change towards this on the wards. There were plans to create separate hospital entrances for the acute mental health wards to enable the environment and reception areas to be less restrictive to their patients. The current entrance was based on a more secure hospital design and patients and staff described the delays that this could cause in entering or leaving the site.

The hospital site was smoke-free at the time of the inspection. Patients were informed of this either before or during admission. The wards encouraged and supported smoking cessation and offered nicotine replacement therapy and/or disposable electronic cigarettes to all patients requiring it.

Safeguarding

The staff we spoke with were confident about how to recognise and report safeguarding concerns.

A member of the senior team was a lead for safeguarding adults and children on the ward. They maintained contact with the local authority safeguarding team for advice on safeguarding concerns. We saw a detailed log of safeguarding concerns raised with the local authority safeguarding team was held by the ward manager to monitor the progress and outcome of investigations.

Staff received annual training in safeguarding adults and safeguarding children. At the time of inspection this training had been completed all staff.

Staff access to essential information

At the morning handover, nursing staff recorded and shared essential patient information from each shift. This was later discussed with the full multidisciplinary team (MDT) at the morning meeting. This included discussing any incidents that had happened overnight and any staffing pressures on the wards.

Staff allocated their roles for each shift at the morning handover. These included: patient allocation to individual nurses, key duties such as supporting patients with section 17 leave, patients who required increased levels of observation or assistance with their physical health. This meant staff had clear information regarding their duties on shift.

Patient information was securely stored on an electronic care records system. All staff, including locum nurses, had a log-in for the electronic patient records which included care plans and risk assessments for each patient. They also had access to the electronic incident reporting system so they could read and report of any serious events that happened on their shift.

Medicines management

Medicines were securely stored in locked cabinets in the ward's clinic room which was also locked. The ward had

Long stay or rehabilitation mental health wards for working age adults

Good ●

secure storage for controlled medicines and managed these safely according to the hospital policy. The medicines were safely stored and disposed of and a pharmacist completed a monthly audit of the clinic room and fed-back any learning to the hospital managers.

There were good arrangements in place with the pharmacy provider to support the medicines management process. The visiting pharmacist reported any medicines issues to the senior team and reported to the hospital governance meeting every three months and reported that the ward doctor and nursing staff were responsive to maintaining good standards.

Staff regularly reviewed the effects of medication on patients' physical health. A suitably experienced member of staff was assigned on each ward as the physical health champion and utilised National Early Warning Score (NEWS) charts to monitor the physical health of every patient daily. We saw appropriate actions taken when the scores from the tests indicated that closer monitoring was required.

We reviewed the medicines charts for several patients which were generally in good order. We found one occasion where a chart for a patient detained under the Mental Health Act contained a medicine that was not recorded on their T2 treatment authorisation certificate. This error had subsequently been amended by the prescribing doctor. However, an incident form had not been completed. We raised this with the ward staff during our inspection.

In all cases a signed patient's consent to treatment form was stored alongside their medicines chart. For patients detained under the Mental Health Act the required treatment authorisation forms were present and had been signed by the clinician in charge of the person's treatment.

Patients' allergies were clearly recorded on the charts.

Track record on safety

There had been 84 incidents of restraint involving 12 patients in the six months ending December 2018. There had been no incidents of rapid tranquilisation in these six months. The hospital did not use prone restraint or train staff in its use.

There had been three incidents of patients being secluded in the six months to December 2018.

The most frequent types of incident on the ward were self-harming behaviours including the ingestion of foreign bodies, tying ligatures, and violence and aggression.

Reporting incidents and learning from when things go wrong

All staff had log-ins to record incidents on the hospital's electronic IRIS reporting system. These were reviewed and signed off by the ward manager and discussed within 24 hours at the daily hospital meeting with the senior team.

The staff we spoke with were knowledgeable about the process for recording incidents and felt confident in using the electronic reporting tool.

The hospital was introducing Safe Wards to all the wards. Safe Wards is a model that helps staff understand and diffuse conflict and flashpoints on the ward and seeks to create a more peaceful environment.

The senior team discussed all incidents at the monthly governance meeting. Learning from incidents was shared by the senior team via a lessons-learned briefing and we saw that these were available to staff in the nursing office on the ward.

Are long stay or rehabilitation mental health wards for working-age adults effective?
(for example, treatment is effective)

Good ●

Assessment of needs and planning of care

We reviewed the clinical records for six patients, which were stored on the electronic care records system. All care plans we saw were in good order, current, and had been regularly reviewed. Patients' immediate and long-term goals were recorded along with the interventions and support required to accomplish these.

The care plans for each patient were individualised, holistic and recovery-focused, and based on the assessed needs of that person. They covered a broad range of recovery goals including the use of dialectical behavioural therapy to focus on mindfulness, interpersonal effectiveness and emotional regulation.

Long stay or rehabilitation mental health wards for working age adults

Good ●

Patients were encouraged by staff to become involved in their treatment and care plans. They were supported to create their own plans and present these to the multidisciplinary team for feedback. All patients had a behaviour support plan which was reviewed frequently with nursing staff. Patients were given a copy of their plans and it was clear that they had been involved in their care plan formulation.

All patients received a physical health assessment on admission including blood pressure, electrocardiogram, blood tests and body mapping. We saw from the care records we reviewed that regular physical health checks were being maintained and recorded in patient notes. The service carried out a monthly audit of the quality of the physical health assessments received by patients.

Patients had access to a GP who visited the ward weekly.

Best practice in treatment and care

Patients were offered a specialised rehabilitation service designed to address the needs of women with complex personality disorders and complex needs. This was delivered in a 12-month rehabilitation programme which combined dialectic behaviour therapy (DBT), support from psychiatry and a programme of recovery activities led by nursing and occupational therapy staff. The use of DBT approaches in the treatment of emotionally unstable personality disorder was an evidence-based approach and was in line with best practice guidance for this patient group.

The rehabilitation programme was led by the ward psychiatrist and the ward lead psychologist with the support of the occupational therapy assistant. Patients had structured days between 9am and 4pm from Monday to Friday. Each morning started with a whole ward goal setting meeting which was followed by a health walk outdoors. Patients attended a DBT-based session each day which focused on skills learning and mindfulness. Patients also had individual therapy sessions with ward psychology staff.

The patients we spoke with were very aware of the nature and duration of their treatment programme. They were encouraged by staff to prepare and contribute to a weekly review of their treatment and progress at the ward multidisciplinary review meeting.

Patients were supported in other activities by nurses and occupational therapy assistants and these included budgeting and shopping, baking, art and relaxation. Patients could also use the hospital gym with support from a trained member of hospital staff.

The patients' progress was measured by recording monthly Health of the Nation Outcome Scales (HoNOS) scores. This was a scale scoring patients' health and social functioning and measuring changes in the levels of their needs over the time of their admission.

Other recognised measures which were used by nursing and psychology staff on the ward to measure patient outcomes included the work and social adjustment scale (WSAS) where patients assessed their levels of impairment in achieving day to day tasks; the Beck depression inventory (BDI) which rated the severity of patients' depressive symptoms, and the CORE outcome measure which patients used to give feedback about the impact of therapy.

Patients were supported by staff to lead healthier lives and this included support with smoking cessation and nicotine replacement therapies, diet and healthy eating and regular exercise. The service employed a full-time health and wellbeing lead and patients had access to a dietician.

Skilled staff to deliver care

The multidisciplinary team comprised one full-time consultant psychiatrist, registered mental health nurses and healthcare assistants, a lead psychological therapist, therapy assistants, an occupational therapist assistant and 1.5 days of a qualified occupational therapist (OT). The OT time available to the ten patients on the ward had recently been reduced by 50% to the current level. Whilst patients were having access to a range of programmes to help with their living skills, they all reported that they would like access to more cooking sessions.

Staff we spoke with told us that they received regular monthly supervision. The hospital target for monthly supervision was 95%. Supervision records showed the ward was meeting this target on most months in the last 12 months but there was some fluctuation when the completion rates fell below target.

Long stay or rehabilitation mental health wards for working age adults

Good ●

There was a clear supervision structure in place with staff receiving support from the relevant professional colleagues and this included staff who were long-term locum workers. Staff also participated in regular reflective practice meetings and locum staff also attended.

The service was up to date with staff appraisals, and all doctors had completed revalidation.

Multi-disciplinary and inter-agency team work

There was a nurses' handover at the beginning of the day and when the night staff replaced the day staff. Daily at 9am there was a hospital morning handover meeting attended by all ward managers, senior leads including the consultant psychiatrist and the hospital director.

Areas covered by the morning meeting included relational security, risk and observation levels, incidents and safeguarding,

Staff and patients told us that the multidisciplinary team worked well together and were effective and approachable.

We saw in patients' records that contact with referring teams, commissioners and other stakeholders in the patients' care pathway was being well maintained by the hospital senior team. This included attendance by community staff at patients' care programme approach review meetings.

Parents, family and carers were invited to the patients' reviews at set times during the treatment programme and could attend the six-monthly care programme approach review meetings.

The ward had a positive relationship with the local visiting GP. The visiting GP supported patients with physical health monitoring and scheduled health check-ups.

Adherence to the MHA and the MHA Code of Practice

At the time of inspection, 98% of ward-based staff had completed mandatory training in the Mental Health Act (MHA). Staff we spoke with demonstrated a good working knowledge of the MHA and the Code of Practice.

There were six patients on the ward at the time of inspection, five of whom were detained under the Mental Health Act.

Staff recorded in patients' electronic notes that they had discussed patients' rights with them.

We saw completed consent to treatment forms for all patients. We identified that one patient had been prescribed a medicine that was not written up on their T2 treatment authorisation form. This had been corrected by the doctor.

The ward had the support of the hospital based Mental Health Act administrator. The administrator sent reminders to staff regarding approaching expiry dates for patients' detention periods and planned patients' tribunals and managers hearings.

Staff recorded arrangements for leave from the hospital (section 17 leave) on patients' electronic notes. Patients told us they could generally take their leave, including escorted leave. However, they also commented that there were times when the ward was very busy and their leave had been cancelled.

Good practice in applying the Mental Capacity Act

At the time of inspection, 99% of eligible staff had completed mandatory training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff we spoke with were aware of the principles of the Mental Capacity Act.

The application of the Act was however carried out solely by the ward doctors but this didn't impact on the timeliness of assessments. We saw in care records that doctors had considered patients' capacity on a decision-specific basis. They recorded capacity assessments regarding specific decisions in the patient's care records.

Are long stay or rehabilitation mental health wards for working-age adults caring?

Good ●

Kindness, privacy, dignity, respect, compassion and support

During the inspection we saw supportive and caring interactions from the staff towards the patients. Staff behaviours were kind and attentive and it was clear that the patients were confident in speaking to the ward staff.

Long stay or rehabilitation mental health wards for working age adults

Good ●

Patients spoke positively about the attitude of the majority of staff and said that the ward doctor and the ward manager were approachable and helpful.

Patients were ambivalent about the quality and choice of meals available.

Patients said that at times they had to wait to get access to the ward garden which was on the ground floor and required staff to escort them as they needed to pass through other parts of the hospital which were locked. At busy times on the ward staff were unavailable to escort and remain with patients in the garden.

Involvement in care

The patients had a daily goal setting meeting attended by staff and patients which focussed on the patient's priorities and activities for the day. There was also a weekly community meeting to discuss where patients could raise concerns and make suggestions about the running of the ward.

Patients were encouraged to take active roles in the planning of their care as part of their rehabilitation process and this included creating their own care plans with the support of nursing and therapy staff.

Patients told us that they were encouraged to include carers and family in planning their care and treatment if they wished to. Patients told us that there were challenges to this as their families had to travel long distances to visit them and on some occasions they were unable to go out with family as they did not have any leave.

Patients took part in a quarterly hospital-wide survey of their satisfaction with the service. The three areas surveyed were satisfaction with staff, with care, and with the ward environment. The highest satisfaction score for patients currently receiving treatment on Amy Johnson ward in the December 2018 survey was that 65% felt listened to by staff, and the lowest score in this period was that 50% of patients would recommend the service to others. These scores were significantly higher in the same period for patients who had been discharged from this ward at 77% and 78% respectively. This demonstrated that patients' feedback scores on their experience increased after treatment.

Are long stay or rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good ●

Access and discharge

There were six patients on the ward at the time of inspection. Two patients had recently been discharged as they had completed their rehabilitation programme. The bed occupancy for the last six months had averaged 90%.

The ward took referrals from NHS commissioning groups and patients were generally referred by their community care co-ordinator. The hospital received referrals from a wide geographical area and this meant that patients could be a long way from their home area.

Staff we spoke with told us that they considered retaining regular contact with services in a patient's local area was important in ensuring that they would have services identified when they were ready for discharge. We saw that community mental health staff from the patients' local teams were invited to care programme approach review meetings. In the last three months of the 12-month programme patients spent increasing amounts of time in the local community as a preparation for discharge.

Criteria for referrals to the ward were female patients with a diagnosis of emotionally unstable personality disorder, including patients with co-morbidities such as trauma, psychosis, Asperger's syndrome or eating disorders. Patients with eating disorders were accepted if their body mass index was above 16.

The ward did not accept referrals if the patient had a history of assaulting behaviour or used violent behaviour. The ward criteria also excluded patients with a diagnosis of anti-social personality disorder or psychopathy.

Patients who were referred received a two-stage assessment. They had a face-to-face assessment with two senior staff and were invited to spend a day on the ward. They then had a second assessment including psychometric tests and interviews and received details about the treatment model and expectations for the programme. This ensured that patients were fully informed

Long stay or rehabilitation mental health wards for working age adults

Good ●

of the nature of the 12-month rehabilitation programme before their admission began. Patients who had been assessed were given the outcome of the assessment process within three weeks.

The average length of stay on the ward at the time of inspection was 255 days. The ward manager told us that there was flexibility with length of stay if patients needed to exceed the 12-month programme in order to secure the most appropriate step-down placement. There were no patients whose discharge was delayed on this ward.

The faclities promote recovery, comfort, dignity and confidentiality

The ward had its own outdoor space. However, the garden was a small slope of grass without any seating, sheltered area or plants. Patients also reported that the access to the garden was dependent on staff taking them through other areas of the hospital to reach it. The hospital director had approved a plan to improve the facilities available in the garden.

The ward had a comfortable central lounge and dining area with television and information for patients. A second lounge area on the ward was furnished with seats and equipped with a television. An activities room and quiet lounge were available to patients.

Patients had en-suite showers in their rooms and there was a ward bathroom equipped with a bath.

All patients had keys to their rooms, and a locked storage cupboard in their bedrooms for personal items. The key for the cupboard was held by the nursing staff.

The flooring and the walls in some of the busiest areas of the ward were showing wear and tear. These areas had limited decoration such as prints, posters or noticeboards to add interest for the patients.

The occupational therapy staff supported patients in a dedicated kitchen area to become more independent with menu planning, shopping and meal preparation.

The patients' activity programme included arts and crafts time, yoga, access to the sports hall and staff organised sports, pampering and time using the ward computers. We saw that staff were supporting patients with an art session during the inspection.

Patients were able to use their own mobile phones and use their vaping devices on the ward. There was a computer room where patients had supervised access to the internet.

Patients' engagement with the wider community

Patients told us they had access to the local community for shopping and when visited by their family. On the day of inspection two patients had escorted leave to visit the local opticians.

Most of the therapeutic programme had ward based therapeutic time and occupational therapy led activities, however patients told us that they had escorted leave to the nearby local town.

Patients' families were welcomed to visit and families meeting with clinical staff was part of the patient's rehabilitation programme.

Meeting the needs of all people who use the service

There was information available to patients on ward notice boards and on admission patients were given an information pack about the hospital. Information included how to raise complaints, safeguarding information, the contact numbers for advocacy services and information about the Mental Health Act and the Mental Capacity Act.

There was a general advocacy service for patients. An advocate visited the ward each week to be available to patients and they had information about how to contact the advocate whenever they needed advice or support.

Staff told us that if they needed information provided in other languages or if a patient required an interpreter the hospital could provide these services.

The hospital had an adapted bathroom and a lift which meant that the ward area was accessible and useable for a patient with mobility difficulties or who required a wheelchair.

Listening to and learning from concerns and complaints

The ward had received four formal complaints in the 12 months to December 2018. Two of the complaints were upheld by the provider, one was partially upheld and one was not upheld. The service had completed an audit of formal complaints in November 2018 to better understand recurring themes and the types of issues that caused patient dissatisfaction.

Long stay or rehabilitation mental health wards for working age adults

Good ●

The ward kept an informal complaints log where patients' complaints were recorded with the hospital response. We saw the completed logs where the ward manager had detailed the actions taken as a result of the complaint and how the response had been given to the patient. Patients were also given information about how to raise formal complaints and this was also posted on the ward noticeboards.

Patients were aware of how to raise concerns and complaints on the wards. There were posters explaining the process around the ward and information in their welcome booklets.

The ward had a weekly community meeting where patients could raise issues and concerns about the running of the ward directly with staff.

Are long stay or rehabilitation mental health wards for working-age adults well-led?

Good ●

Leadership

There was a clear organisational structure at Priory Hospital Burgess Hill and the roles of professional and managerial leads comprising the multidisciplinary team were defined. The senior team were appropriately qualified and they had significant experience of delivering mental health services.

We observed that the medical director, ward manager and senior psychologist were frequently present on the ward and their interactions with staff and patients were warm and respectful.

Vision and strategy

The ward senior team spoke positively about the strengths of the therapeutic programme on the ward. They could describe openly the areas in which they wished to see improvements in the ward environment and demonstrated that they had strategies to make the changes.

Staff we spoke with had a clear view of the purpose of their ward as a rehabilitation service offering a recovery focused treatment programme. The provider had produced a clear service description stating the model of care, the criteria for admission to the hospital and the outcome measures used to mark patient progress to discharge in to the community.

Staff were positive about the ward purpose and shared real pleasure that two patients had been recently discharged after successfully completing their rehabilitation programme. However, staff expressed some concern that the current staffing numbers on day shifts meant that there was always pressure to complete all the ward tasks and meet patients' needs including escorted leave.

It was evident that staff were working in a compassionate and collaborative way to help patients build skills and confidence and this extended in to supporting patients to have an active role in making decisions about their care and treatment.

Culture

Staff were positive about the atmosphere and the ethos of the ward. They spoke warmly about the support they received from colleagues and the senior team.

Staff were receiving regular supervision, training and appraisal.

Staff we spoke with told us that they felt confident about raising any concern they had to senior staff. All staff were aware of the organisations whistle-blowing policy.

Governance

There was a clear governance and reporting structure within the hospital and up to the larger organisation. The hospital had a daily morning meeting to review any significant events and risks, including incidents and staffing. This meant that priorities that affected the ward were reviewed every day.

There were daily patient planning meetings and a weekly patient community meeting and issues raised at these were shared at team meetings and at the hospital governance meeting.

Senior management conducted monthly quality walk round visits of the wards and put in actions plans to address any concerns found.

We saw that learning from incidents, complaints and safeguarding across the hospital were shared with all ward staff.

Long stay or rehabilitation mental health wards for working age adults

Good ●

The hospital held regular forums where issues concerning the wards were discussed and actions taken. These included a monthly governance meeting also a weekly ward management meeting. All patients on the ward had a weekly review of their care with the multidisciplinary team.

Management of risk, issues and performance

The ward manager had access to a dashboard of information which was mostly drawn from patients' electronic clinical notes and the incident reporting system. This showed a broad range of patient-related indicators and performance against agreed targets. A monthly report was created for the ward performance and included mandatory training, incidents, complaints and medicines.

The hospital risk register was reviewed by the senior team each month and detailed actions to mitigate each risk were recorded, and where appropriate an action plan had been developed to monitor progress to reducing or eliminating the risks. Current high risks included recruiting and retaining suitable staffing, the high levels of acuity of the patients on the wards, and the levels of therapeutic activities available to patients.

The ward staff we spoke with could articulate the service's risks and the mitigations and strategies that were in place to further reduce and manage them.

Information management

All ward staff had access to the wards clinical records system for patients which meant that staff, including locum staff, had the most current patient information.

The incident reporting tool was linked to the patients' records so if a patient was involved in an incident, the details also appeared on the patient's record. This helped maintain patient and staff safety on the ward.

All staff were up to date with their training in information governance. The mandatory courses included data protection and confidentiality, cyber security and IT security. This helped staff recognise how to safeguard confidential information relating to patients and staff.

Engagement

Staff that we spoke to were positive about their jobs and working at the service.

Staff had access to up to date information about the work of the provider through the intranet, bulletins and notices in the ward offices.

Community meetings were held weekly on all units to allow patients the opportunity to provide feedback on the service.

The ward had access to feedback from families and patients. The ward sought feedback from patients who had been completed their treatment and had been discharged.

The service made appropriate notifications to external agencies, such as local safeguarding teams.

Learning, continuous improvement and innovation

The ward took part in the Priory annual audit programme which included in 2019 an audit of patients' sexual safety plans, and an audit of self-harming behaviours to identify trends and take actions to reduce the incidents of self-harm.

At the time of inspection this ward was not participating in any formal accreditation scheme.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all abnormal physical health risks are followed up.
- The provider must ensure that all patients in seclusion receive medical reviews according to the hospital policy and the Code of Practice.

Action the provider SHOULD take to improve
Action the provider SHOULD take to improve

- The provider should ensure they reduce medicine errors, appropriately label 'to take out' medicines and provide sufficient patient information.
- The provider should dispose of expired medicines in line with organisational policy.
- The provider should ensure that clinic room refrigerators are kept clean at all times.

- The provider should ensure cleaning standards are maintained and that ward staff are aware of the domestic teams' responsibilities and schedule.
- The provider should support the wider MDT to have confidence in carrying on MCA assessments if they are the most appropriate person.
- The provider should ensure that repairs to the ward are carried out in a timely way.

- The provider should ensure that patients have access to hot and cold drinks on Amy Johnson ward and that patients have more opportunities to prepare their own meals as part of the rehabilitation programme.

- The provider should ensure that patients have greater access to the ward garden and it is suitably furnished with seating and a sheltered area.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe Care and Treatment** The provider did not complete medical reviews for a patient in seclusion according to the provider policy on seclusion and the Mental Health Act Code of Practice guidance. The provider did not follow up the physical health concerns for a patient following an abnormal ECG reading. This was a breach of regulation 12.

Enforcement actions

Action we have told the provider to take

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