Partnerships in Care Limited

# Priory Hospital Dorking

**Inspection report**

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

## Ratings

| | |
|---|---|
| Overall rating for this location | Good |
| Are services safe? | Requires Improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Good |

# Summary of findings

## Overall summary

Priory Dorking Hospital provides Acute care for adults of working age.

This was the service's first inspection. We rated it as good because:

- Staff assessed and managed patients' risks well. They minimised 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.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards including nurses, doctors, a clinical psychologist, a psychology assistant, an occupational therapist, and occupational therapy assistants. 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 understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- 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.
- All patients said that the care and treatment they received was good and that staff behaved kindly towards them.
- The service managed access to beds well and discharged patients promptly once their condition warranted this.
- The service was well-led.
- Staff felt respected, supported, and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

However:

- The provider did not manage ligature risks well. The tools and audits used by the provider did not adequately assess and manage potential ligature anchor points. A ligature point is anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. There were multiple ligature points in parts of the ward which the provider had not sufficiently mitigated. The provider did not have a robust ligature risk assessment in place at the time of our inspection to remove all ligature risks. The provider did not have governance processes in place to enable the systematic review and management of environmental ligature risks. We were concerned that the governance around how ligature risks were systematically audited, reviewed, and actions carried out were not evident or documented. Due to the nature of the concerns, we escalated our concerns to the management team, and the provider gave us immediate assurance of how they were going to mitigate the ligature risks and provided a robust action plan immediately after our inspection visit.
- Leaders did not always have oversight of the safety of the ward.
- Staff did not always ensure patients' medicines were managed safely. We checked medicines and found that several medicines including tablets, liquid, and creams were out of date**.** We ensured the provider had removed the out-of-date medicines from the cupboard during our inspection.
- We identified that some medical equipment was out of date such as back up pads for a defibrillator and some syringes which were out-of-date. We ensured the provider had removed the out-of-date equipment from the cupboard during our inspection.

# Summary of findings

- Staff did not always review and record the effects of intramuscular rapid tranquilisation on the patients' physical health including regular checking of their vital observations. Therefore, staff could not potentially detect any harmful physical health deterioration of the patients to mitigate against or reduce the risk of harm.
- We identified gaps in the National Early Warning Signs (NEWS2) records because staff stored NEWS2 information on both paper record and electronically. Staff could not frequently total NEWS2 scores so staff could not quickly escalate any serious concerns to the clinical team.
- Not all ward areas were clean, well maintained and fit for purpose. Most parts of the ward looked very 'tired' and needed maintenance and redecorating. We found damaged doors, flaking paintwork and holes in walls on the ward.
- The service did not have enough permanent registered nurses but was in the process of recruiting to vacancies.
- The occupational therapy team did not provide enough therapeutic activities for the patients during the weekend.

# 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  | |

# Summary of findings

## Contents

# Summary of this inspection

## Background to Priory Hospital Dorking

The Priory Hospital Dorking is an independent hospital and is part of the Priory Group (Partnerships in Care). The service supports males of working age, experiencing an acute mental health episode, providing the necessary levels of care required during crises.

The focus of their service is to stabilise and support patients on a pathway to community discharge as soon as possible, with the appropriate aftercare in place.

This new service has not previously had an inspection since changing name and its service provision to acute wards.

Priory Dorking is registered with CQC to provide the regulated activities of assessment or medical treatment for persons detained under the Mental Health Act 1983, Diagnostic and screening procedures and Treatment of disease, disorder, or injury.

We undertook an unannounced comprehensive inspection to determine if the service was providing safe care to males of working age, experiencing an acute mental health episode.

The service was previously registered with CQC as Pelham Woods and provided rehabilitation services for females with Emotionally Unstable Personality Disorder (EUPD). The service re-registered with CQC as Priory Dorking in December 2021 as an 18-bedded acute mental health service. At the time of inspection, there were 14 detained and 4 informal patients.

CQC inspected the service under the previous provider on 31 October 2018 and rated the service good over all with outstanding in well-led.

The service did not have a registered manager in post at the time of this inspection.

## How we carried out this inspection

Before this inspection, we reviewed information we held about the service including information discussed at provider engagement meetings. The inspection was unannounced.

A team consisting of two CQC inspectors, a specialist advisor with experience in working in mental health services and an expert by experience visited the service.

During the inspection visit, the inspection team:

- toured the ward to look at the quality of the ward environment.
- spoke with 9 patients.
- spoke with 1 carer on the ward.
- spoke with 14 members of staff including the hospital director, clinical lead, ward manager, ward consultant, locum occupational therapist, locum psychologist, quality lead for Priory south region, medical director, assistant psychologist, nursing staff, health care assistants, and a housekeeper.
- observed the hospital daily flash meeting.

# Summary of this inspection

- observed Multidisciplinary Team (MDT) handover and ward round.
- reviewed 9 patient care records and risk assessments.
- reviewed 8 prescription charts.
- inspected the clinic room.
- reviewed incidents, complaints, and compliments records.
- reviewed a range of policies, procedures and other documents relating to the running of the wards.

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

## Areas for improvement

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

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(2) (a) (e) (g).

- The provider must ensure that all ligature risks are managed well in the garden and multifaith room and that there were clear plans in place to remove or mitigate against such risks.
- The provider must ensure staff complete the necessary physical health monitoring for patients who received medicines by intramuscular rapid tranquilisation, to protect patients from significant physical health deterioration.
- The provider must ensure that staff used one system of recording to record weekly National Early Warning Signs (NEWS2) scores of patients. This process could help staff to detect a patient whose physical health is deteriorating so that staff could quickly escalate any serious concerns to the clinical team.
- The service must ensure that there are robust systems in place to check medicines and medical equipment to ensure all out of date items are detected and disposed of.

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

- The provider should ensure that governance processes are in place to enable the systematic review and management of environmental ligature risks.
- The service should ensure improvements are made to the general ward environments to ensure the environment is well maintained, decorated to a good standard, and fit for purpose.
- The service should ensure patients receive therapeutic activities during the evenings and at weekends.
- The service should ensure there are other religious text in the multifaith room for patients to access as well as the Bible.
- The service should continue to make every effort to recruit permanent registered nurses.
- The service should ensure care plans are completed collaboratively with patients and includes patients' voice.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Acute wards for adults of working age and psychiatric intensive care units** | Requires Improvement | Good | Good | Good | Good | Good |
| **Overall** | Requires Improvement | Good | Good | Good | Good | Good |

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

Good

| | |
|---|---|
| Safe | Requires Improvement |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Is the service safe?

Requires Improvement

This was the service's first inspection. We rated safe as requires improvement.

### Safe and clean care environments

**Not all ward areas were clean safe and well maintained but the ward was well equipped, well furnished, and fit for purpose.**

### Safety of the ward layout

The nursing office did not allow staff to have a clear view of all the corridors on the ward. Staff consistently walked around the ward and checked on the whereabouts of patients to ensure patients were safe. We saw that the provider had installed convex or parabolic mirrors on all blind spot areas of the ward and had installed extra closed-circuit television (CCTV) to cover areas of the garden which the staff identified as difficult to continuously observe.

The ward complied with guidance and there was no mixed sex accommodation.

Tour of the ward raised concerns about ligature points. We found fixed ligature anchor points and high-risk ligature points across the ward without sufficient mitigations in place to manage the risks at the time of the inspection. For example, we saw that the multifaith room had high beams which had large bolts and nuts with anchor points which patients could use as a potential fixed ligature point, but the service did not have clear mitigations in place to manage the ligature risks. We were concerned that if patients went to pray in the multifaith room unsupervised, they could easily stand on furniture to harm themselves.

The window in the multifaith room had a gap above them even though the widow had a restricted opening. The inspection team were concerned patients could easily attach a ligature to the window to cause harm to themselves. However, the service did not have clear mitigations around this ligature risk.

We reviewed the garden area and saw that there were mesh fittings and fixtures in the garden such as gutters which could easily hold weight. There was a large wire hanging down in the garden, as well as lamp wires and a tube. We were concerned that the garden was open and accessible all day and night by patients even though staff did not constantly monitor the patients. There was no full CCTV coverage in the garden areas, and this could potentially put the patients at risk of tying a ligature when accessing the garden area.

We escalated these concerns to the senior management team during our feedback session following the inspection. The manager gave us an interim verbal assurance to immediately mitigate the risks by closing the secure garden during the night. The manager assured us that patients would only access the garden with the presence of staff in the garden. Staff would also support patients in the multifaith room in the short term. We received an action plan and ligature risk assessment from the manager few days after our inspection and the plan provided details of immediate actions the service had taken to mitigate the ligature risks in the service. For example, the manager escalated the risks to the managing director, the estate management team and completed ligature risk assessment for both the garden and the multifaith room. As part of the short-term mitigation plan, the service restricted patients' access to the garden to specific times of the day and for staff to be present when patients accessed the garden and the multifaith room. The service would re-activate the CCTV in the garden. Staff discussed interim arrangements with the patients in their recent community meeting. We assured ourselves of the immediate action that the managers put in place to mitigate the ligature risks in the service.

All staff and visitors had access to personal alarms to be able to call for support when required. The ward had nurse call alarms in all patients' bedrooms and communal areas. A panel in the nursing office displayed the area of concern if a patient or staff activated the alarm.

Patients always had access to their bedrooms. The bedroom doors were anti-barricade and had a vision panel which enabled patients to have privacy which allowed staff to conduct observations in an unobtrusive way.

### Maintenance, cleanliness, and infection control

Not all ward areas were clean, well maintained and fit for purpose. For example, there were cobwebs on the inside of the window frames and on the high beams in the multifaith room. The door leading to the visitor's room had spills and stains on it. The visitors room had plaster, coming off the floor, walls as well as crayon and pen marks on the walls. We also found holes, flaking and damaged paint work on the walls. We identified a broken blind in the visitor's room and therefore someone standing in the reception area could view the room from a distance which did not support patient's privacy. The door leading to the admin office was damaged and needed repairs. Most parts of the ward looked very 'tired' and needed redecorating. However, the murals on the walls were beautiful.

Staff followed infection control policy, including handwashing, and completed enhanced infection control checklists every day. The staff managed infection prevention and control processes well and had access to personal protective equipment (PPE).

The service had good process for maintenance works and had a maintenance log where staff reported maintenance issues. The maintenance team ensured they promptly worked on maintenance issues raised by patients. Staff discussed maintenance issues as a standing item on the agenda during the morning flash meetings.

The ward had a dedicated house-keeping assistant who followed a planned cleaning schedule. Staff stored cleaning materials safely in a locked cupboard on the ward.

### Seclusion room

The ward had a newly built seclusion room which allowed clear observation and two-way communication. The seclusion room had all the recommended facilities to make it safe for use such as a toilet, bath parabolic mirrors, and a clock. It had an added Bluetooth facility which allowed patients to listen to music if they wanted to. The service designed the seclusion room to meet the provider's safety standard and for staff to have a clear line of sight in the bathroom. However, the seclusion room was not in use at the time of the inspection because staff were undergoing training to be able to use the facility effectively.

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

Good

### Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment and kept up to date records of this. Staff locked the medicines fridge and completed daily temperature checks. The ward had a defibrillator which staff checked weekly. All equipment was appropriately calibrated, with weekly clinical room checks recorded by the nurse in charge, and a pharmacist. A crash bag including ligature cutters was readily available. We found three oxygen cylinders which were almost full in the clinic room. However, we found that a backup pad for the defibrillator and syringes were out of date.

### Safe staffing

**The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.**

### Nursing staff

The service had a staffing matrix and we saw that the managers met the minimum staffing numbers on most shifts. Staff worked 12-hour shifts with six staff on the day shift which comprised of three qualified nurses and three health care assistants (HCAs). The nighttime staffing matrix was five staff which included three registered nurses and 2 HCAs.

The service relied heavily on bank and agency staff to cover shifts, especially during the night and periods of unexpected sickness or absence. Managers mitigated this by sometimes covering shifts themselves or using familiar and regular agency and bank staff when needed to ensure the ward was safe. The service had a pro-active recruitment drive underway including recruitment of international nurses and other professionals. Staff were part of a messaging service group through which staff contacted each other to cover shifts when shifts needed.

The service had reducing vacancy rates. At the time of inspection, managers told us the service had vacancies for seven registered mental health nurses (RMN) and five HCAs. The service had a vacancy for a consultant psychiatrist because the current consultant was moving to another service. Managers told us the service had recruited five HCAs and one RMN who were going through employment checks and induction. The service had also recruited a locum OT who started working two weeks prior to our inspection visit and a physical health nurse who was going to start working a day after our inspection. Two staff old us the service had high vacancy rate because the service did not provide incentives such as weekend pay enhancement which attracted staff to continue working for the service.

The service had low and reducing rates of bank and agency nurses and support staff. For example, the service used 37% of both locum agency nurses and HCAs. Managers limited their use of bank and agency staff and requested staff familiar with the service. We spoke with both agency and bank staff during our visit who told us they had previously worked on the ward and were familiar with the patients.

The service had low and / or reducing rates of bank and agency nursing assistants because the service hired more HCAs.

Managers ensured all bank and agency staff had a full induction and understood the service before starting their shift. The service gave ward inductions and necessary information for working on the ward to bank and agency staff who were not familiar with the ward. The managers ensured staff received handovers at the start of each shift to ensure staff received detailed information about patients before starting their shift. The manager informed us they requested and ensured the mandatory training and experience of bank and agency staff matched the minimum standards required for working in the service before the manager deployed staff to work on the ward. However, 7 patients told us agency staff were sometimes passive, did not appear to be well trained. Patients said agency staff sometimes acted like security guards and did not have much interaction with patients.

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

Good

The service had low turnover rates. The data provided for the hospital showed staff turnover rate was 34% and 33 % for May and June 2023, respectively. The manager indicated that the turnover rate related to bank and agency staff that had not worked on site for more than 6 months.

Levels of sickness were high. The data given to us showed sickness levels for the hospital was 6% for the month of June compared to May which was 1%. The hospital had a sickness target of 4.5%. Managers supported staff who needed time off for ill health.

Managers accurately calculated and reviewed the number and grade of nurses, and healthcare assistants for each shift. The nurse in charge and senior management team (SMT) had the autonomy to adjust staffing levels according to the needs of the patients. The manager planned and discussed the staffing levels for each shift during daily multidisciplinary team (MDT) handover according to the level of risks on the ward.

Patients had regular one to one session with their named nurse. We observed staff spending time with patients on the wards, and patients knew who their named nurses were.

Staff told us patients sometimes had their escorted leave or activities cancelled when the service was short staffed. If needed, staff re-arranged escorted leave to a time when it was safe to do so.

Staff told us the occupational therapy team were always available to facilitate activities, and suggested activities to staff to engage the patients at weekends. However, six patients told us there were not enough activities over the weekend due to shortage of staff.

The service mostly had enough staff on each shift to conduct any physical interventions safely and patients had regular one to one session with their named nurse. However, two staff told us sometimes the ward was short staffed or staffed with inexperienced and unconfident staff which made is unsafe to conduct physical interventions.

Staff shared key information to keep patients safe when handing over their care to others. Managers held daily flash meetings to discuss any incidents, datix reporting, safeguarding admission and discharges, staffing & maintenance issues.

### Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. For example, the ward had a dedicated consultant and a locum speciality doctor who worked full time and had recruited a permanent speciality doctor who is due to start in October 2023. The service had an on-call duty rota to cover out of hours.

The ward had access to two resident medical officers (RMOs) who worked alternative weeks to cover out of hours every day. We spoke with the ward consultant, who told us they were satisfied with the medical support available on the ward. The staff team told us they felt this level of medical input was workable and felt they could contact the consultants and doctors outside of their working hours if needed.

Managers made sure all locum staff had a full induction and understood the service before starting their shift. For example, the manager ensured that the provider's preferred agency to supply RMO to the hospital, complied with all the training expectations of the provider. However, two staff told us due to staff shortage sometimes, the manager deployed inexperienced staff to work on the ward which put both patients and staff at risk of harm.

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

Good

## Mandatory training

Managers had a system which monitored mandatory training and alerted staff when they needed to update their training. Over 83% of staff had completed all mandatory training courses.

The mandatory training delivered to staff included a combination of face to face and online training and staff felt the mandatory training programme was comprehensive.

The manager encouraged agency staff to undertake training in reducing restrictive intervention through the provider's academy to ensure consistency in learning and approach.

## Assessing and managing risk to patients and staff

**Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating, and managing distressed behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.**

## Assessment of patient risk

Staff used the Dynamic Appraisal of Situational Aggression (DASA) screening tool, which staff completed with input from the ward psychologist to assess patients' risk on admission. The tool was appropriate for the patient group the team treated on the ward. Staff obtained information about patients' risk from each patients' previous placement, family and from the patient on admission. However, staff could not always capture all information of patients at the point of admission.

We looked at the care records of nine patients. All records we reviewed contained up-to-date risk assessments in care notes which staff reviewed regularly. The risk assessments were comprehensive, and staff had good working knowledge of the risks of all the patients.

Patient risk assessments and risk management plans were informative, individualised, reviewed regularly. The MDT reviewed patients' risks during ward round.

## Management of patient risk

Staff managed risks to patients well. Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients.

Staff could easily observe patients in all communal areas of the ward and followed procedures to minimise risks in restricted areas including regular observations at a frequency depending on each patient's risk.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff noted what patients were wearing before going out on leave, to aid their return in the event of them going missing or absent without official leave. Staff also conducted regular drug testing for patients when it was necessary to do so.

## Use of restrictive interventions.

Levels of restrictive interventions were low and / or reducing.

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

Good

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Managers held monthly meetings to review restrictive practice audits, identify lessons learnt and examples of good practice. Managers discussed restrictive intervention at MDT level meetings.

Staff received three days reducing restrictive practice (RRIT) training as part of their induction and mandatory training. The manager did not deploy staff who had not completed RRIT training to work on the ward. The service had patients' safety groups and facilitated community meetings with patients to get patients involved and express their views regarding restrictive practices on the ward.

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

Staff told us they used reduced RRIT or rapid tranquilisation (RT) to manage patients who showed distressed behaviours but prioritised de-escalation, appropriate observation levels to keep patients and staff safe on the ward.

Staff did not always follow National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Staff were able to describe the physical health checks that they would conduct immediately following rapid tranquilisation, although the ward rarely used rapid tranquilisation and had not used RT in recent months on ward.

Staff did not place patients in seclusion because the ward did not have a functional seclusion facility at the time this inspection. At the time of the inspection, we inspected a newly built seclusion facility which was not operational because the provider was training the staff on how to use the facility.

No patient was on long term segregation at the time of our inspection activity.

## Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Staff received training on how to recognise and report abuse, appropriate for their role and kept up to date with their safeguarding training. The staff safeguarding training compliance rate for the ward was 84%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. One staff member spoke of how they had supported a patient who had fluctuating capacity to make an informed decision about their care.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies including the local authority safeguarding team to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The service had access to two safeguarding leads who supported the staff to make safeguarding referrals if need.

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

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

Good

## Staff access to essential information

**Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records whether paper-based or electronic.**

Staff stored information needed to deliver care, including patient records, securely and were available in an accessible form to staff when they needed it.

Staff used a combination of paper and electronic notes to record care and treatment provided to patients. Staff stored paper notes securely in the locked office and these included comprehensive assessments, risk assessments and care plans.

Patient notes were comprehensive, and all staff could access them easily.

## Medicines management

**The service did not always follow systems and processes when safely prescribing, administering, recording, and storing medicines. Staff did not always ensure that when patients were administered rapid tranquilisation, appropriate physical health checks were completed in line with national best practice.**

Not all medicines were in date. For example, we checked 30 medicines and found 5 medicines including a variety of creams, tablets and liquid were out of date. We removed the out-of-date items from the cupboard and the provider disposed of them on the day of inspection**.** The ward's medication audit or external pharmacy audit which the service conducted weekly could not pick up out-of-date items. We reported our findings to the management team as part of our feedback post inspection.

The managers provided additional evidence following our inspection which demonstrated the service had put immediate systems in place to ensure that different nurses completed and recorded medicines stock checks. The service ensured their contracted pharmacy audited the medicines stocks, disposed of all expired medicines, and highlighted all medicines expiring within 3 months.

Staff regularly reviewed and provided specific advice to patients and most carers about their medicines. We spoke with nine patients, and they all told us they received information about their medicine.

Doctors reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines in ward rounds. We looked at medicines chart for eight patients on the ward and found that staff completed the records accurately with no gaps, and allergies recorded as appropriate. Staff informed the ward doctors when patients refused their prescribed medicines.

Staff stored and managed all medicines and prescribing documents safely. Staff stored all medicines and related documents in the clinic room. The ward had appropriate storage facilities and recording books that staff used if a patient needed to store controlled drugs on the ward.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

The service did not always ensure staff did not control people's behaviour by excessive and inappropriate use of medicines. For example, we found three incident reports where staff administered rapid tranquilisation to a patient, but staff did not record the rationale for its use or whether staff tried to use other de-escalation techniques or patient's response to the rapid tranquilisation.

Staff did not always review the effects of each patient's medicine on their physical health according to NICE (National Institute of Clinical Excellence) guidance including monitoring of blood tests and regular checking of their vital observations. For example, we saw three incident records where staff administered rapid tranquilisation to a patient, but staff did not record the effect of the rapid tranquilisation on their physical health in their care notes. The patient refused physical health check post RT. However, there was no record of non-contact observations. For example, level of consciousness, and respiratory rate in their care record.

### Track record on safety

**The service had a good track record on safety.**

### Reporting incidents and learning from when things go wrong.

**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. When things went wrong, staff apologised and gave patients honest information and suitable support.**

Staff knew what incidents to report and how to report them in line with provider's policy. Staff had received training on how to report incidents and staff discussed incident reporting as part of staff supervision. Staff produced detailed incident reports and recorded all relevant information appropriately.

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

Staff reported incident using the hospital's electronic incident record. Types of incidents reported included physical aggression from patient to patient or patient to staff and property damage, and medicines error.

The ward had no never events since it opened.

Staff understood the Duty of Candour and their responsibilities. Staff we spoke with understood the need to be open and transparent when they made mistakes and to apologise when required. The Duty of Candour regulation explains the need for providers to act in an open and transparent way with people who use services. It sets out specific requirements that providers must adhere to when things went wrong with people receiving care and treatment. The provider had a Duty of Candour policy in place.

Managers and members of the senior management team (MDT) debriefed and supported staff and patients after any serious incident. The manager told us patients engaged in debriefs as part of their recovery journey. For example, staff told us they felt well supported and managers gave them the opportunity to debrief immediately following incidents and received regular reflective practice sessions led by the psychologist. Staff also held weekly multi-disciplinary team meetings where the team discussed serious incidents. However, two staff informed us that they could not always attend reflective practice sessions due to the demands of the ward.

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

Good

Mangers investigated all incidents. Incidents that met the providers serious incident criteria, which staff rated as serious or catastrophic, had a 72-hour report and full root cause analysis completed. Managers regularly reviewed actions from these reports during monthly governance meetings to track their progress. We reviewed one serious incident of aggressive behaviour of a patient and found the report had details and contained identified learning and actions.

Staff received feedback from incidents and investigations, from both professionals within the Priory group and from external professionals such as the local safeguarding team.

Staff discussed lessons learnt from incidents were during handovers and staff meetings. The clinical lead sent out a monthly lesson learnt bulletin to all staff via email and staff kept printed copies in the nursing office. We found a lesson learnt board in the office where the manager posted information about lessons learned for staff to read. All staff we spoke with were able to give examples of lessons learnt from incidents which had taken place on the ward.

## Is the service effective?

Good

This was the service's first inspection. We rated effective as good.

### Assessment of needs and planning of care

**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 patients' assessed needs, and were personalised, holistic and recovery oriented.**

All patients had care plans in place which included short and long-term strategies for how to manage their needs and staff completed updated the information within 72 hours after the service admitted the patient to the ward. Staff reviewed care plans regularly and discussed care plans during ward rounds. Care plans were informative, up-to-date, personalised, and included the views of the patient, where possible in line with the National Institute for Health and Care Excellence (NICE) guidance. However, we identified that three of the care plans did not include patients' voice.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The team completed physical health assessment for patients on admission. Doctors conducted blood tests and an electrocardiogram for all patients. Doctors checked patients' weight and vital signs as well as their blood sugar for signs of diabetes. Staff reviewed each patient's physical health throughout their admission according to the specific needs of the patients.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic and recovery-orientated with four sections covering 'keeping safe,' 'keeping healthy,' 'keeping connected, and 'keeping well.' Staff recorded these on the provider's electronic records system used paper records for physical health and fluid charts.

Staff told us that they regularly reviewed and updated care plans when patients' needs changed. The multidisciplinary team reviewed each patient once a week and updated patients' records after these reviews which we confirmed in the 9 patient records we looked at.

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

Good

## Best practice in treatment and care

**Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives.**

Staff provided a range of care and treatment suitable for the patients in the service. The ward admitted patients for the treatment of acute mental illness. Assessment and treatment of patients involved prescribing medicines, providing psychology sessions to individuals and in groups and facilitating creative, educational, and therapeutic activities. Staff described the ethos of the ward as focused on preventing further admission, rather than focusing entirely on the immediate crisis.

Staff identified patients' physical health needs but did not record physical health information appropriately in their care plans. For example, during the inspection, we identified that staff completed vital checks for patients but could not tell if the checks were frequent for some patients or not. We also identified gaps in the National Early Warning Score (NEWS2) charts for three patients. Staff did not frequently record and total NEWS2 scores for the patients. Staff used a mixture of a Microsoft word document and electronic system which was not compatible with NEWS2 standard of recording and monitoring physical health observations for patients. Therefore, staff got confused about which records to use and could not easily identify and escalate physical concerns to the clinical team.

Staff ensured that patients had access to physical healthcare. Patients received a physical health examination on admission and doctors reviewed their physical health at least once weekly depending on individual circumstances. The resident medical officer checked the physical health of patients once a week. Patients were able to access other specialist services such as opticians and podiatry and dentist. The hospital had a gym and a personal trainer that patients could access for exercise.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. For example, staff used nutrition and hydration charts to monitor the food and fluid intake of a patient who had restricted their food intake. Patients had access to a dietician and the kitchen served patients with healthy food.

Staff encouraged patients to live healthier lives by supporting them to take part in programmes or giving advice. Staff discussed non-smoking issues in community meetings and offered patients the opportunity to quit smoking by offering patients, e-cigarettes, and nicotine replacement therapy (NRT) such as patches and lozenges. However, not all patients accepted the e-cigarettes and nicotine replacement therapy. For example, incidents on the ward increased when staff tried to enforce no smoking rules. The service had an onsite gym with a personal trainer who attended the site on weekends to support patients with physical exercise. The trainer inducted the patients on how to use the gym and completed risk assessment before each patient used the gym. The ward had food charts to monitor what patients were eating and encouraged patients to walk around as a form of exercise.

Staff used recognised rating scales to assess and record severity and outcomes. Staff used Health of the Nation Outcome Scale (HoNOS) to record and review each patient's progress. Staff also provided examples of using physical health rating scales with patients, including the modified early warning score (NEWS2).

The team provided a comprehensive approach to care by using a multi-disciplinary approach with patients being at the centre of their care. The service had just recruited a new OT who started working in the service two weeks before our inspection visit. The OT informed us the occupational therapy team used the MOHOST (Model of Human Occupation Screening Tool) when working with patients.

Staff took part in clinical audits, benchmarking, and quality improvement initiatives. Managers held monthly meetings to review restrictive practices and lessons learnt from incident audits. The manager fed back areas which required further learning and areas of good practice to staff in a variety of formats. For example, through daily team briefings, 1-1 supervision, and emails. The managers were also in the process of introducing the "Safeward" policy into the wards which has the aim of minimising the number of conflicts between healthcare workers and patients that could lead to the use of restrictive interventions.

The service conducted regular audits to check if outcomes for patients were positive. For example, mangers run weekly audits on care plans and ensured that each patient was allocated to psychologist and a clinician to manage their care. Managers also ensured that patients had their section 132 Mental Health Act rights read to them. Managers used results from audits to make improvements.

### Skilled staff to deliver care.

**The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed 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 inexperienced staff.**

The ward teams included or had access to the full range of specialists required to meet the needs of patients. These included, qualified nurses, nursing assistants, a consultant psychiatrist, Clinical psychologist, assistant psychologist speciality doctor, an occupational therapist, OT assistants and a dietician.

Managers ensured staff had the range of skills, qualifications, and experience needed to provide high quality care to meet the needs of the patients in their care. For example, because staff worked on a ward identified as having considerable risk of restraint and restrictive interventions, managers encouraged staff to attend RRIT training to update their knowledge in this area. Staff told us the RRIT had helped them increase their confidence in responding to incidents.

Managers supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Managers provided an induction programme for inexperienced staff including bank and agency staff.

All staff received an appropriate local and corporate induction. Induction packages were available for clinical staff, non-clinical staff, bank staff and agency staff. Induction provided staff with information on organisational policies and procedures and provided the opportunity to work supernumerary to ward staffing numbers. Staff also completed a ward specific orientation and induction. For example, staff told us the induction they received prepared them for their role, and experienced staff guided staff through the induction process and acted as their mentors.

Managers supported staff through regular, constructive appraisals of their work and monthly one to one supervision sessions. Staff told us they had an opportunity to raise any concerns they had about the service during supervision sessions. Supervision Records showed that 100% of staff had clinical supervision in the last month. The manager had regular supervision with the regular bank and agency staff that worked in the service.

Managers made sure staff attended regular team meetings. Managers followed an agenda, recorded team meetings, and sent copies of the meeting minutes to all staff including those who could not attend the meeting. Minutes of recent

team meetings indicated that topics discussed included ward audits, governance, incidents, lessons learnt, training and positive comments and complaints. Staff spoke positively about team work on the ward and support provided by their line managers. Managers monitored the number of hours staff worked to ensure they had breaks and used their annual leave.

Managers identified any training needs of their staff and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. For example, staff received training in reducing restrictive intervention (RRIT) and Dialectical Behavioural Therapy (DBT), leadership level 2 training. One staff told us they received specialist training in venepuncture (taking bloods). Staff said they felt they had the right skills to do their job. Staff told us they had access to the provider's academy to enrol on any specialist training they required.

Managers recognised poor performance, could identify the reasons for poor performance and dealt with these. Managers told us they had access to human resources support for dealing with poor staff performance. At the time of our inspection, there were no performance issues reported on either ward.

### Multi-disciplinary and interagency teamwork

Staff held regular multidisciplinary meetings to discuss patients and improve their care and made sure they shared clear information about patients and any changes in their care, including during handover meetings.

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff told us that they had access to support and advice on implementing the Mental Health Act and the Code of Practice. Records we reviewed showed that 96% of the staff were up to date with their Mental Health Act training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice and knew who their Mental Health Act administrator was and when to ask them for support.

The service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Patients had easy access to information about independent mental health advocacy and staff automatically referred patients who lacked capacity to the advocacy service. The service posted information about the advocacy service on the notice board in the dining room.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, and staff repeated this information verbally to the patients and for most patients, staff clearly recorded the information in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when the responsible clinician agreed.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Staff told us they scanned the section papers and saved them securely onto patients' electronic records.

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

Good

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits with the findings made available to all staff.

### Good practice in applying the Mental Capacity Act

**Staff supported patients to make decisions on their care for themselves. They understood the service policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.**

Staff received and kept up-to-date with training in the Mental Capacity Act and staff we spoke with had a good understanding of the five principles. Records we reviewed showed that 74% of the staff had completed their training in MCA.

There was a clear policy on the Mental Capacity Act which staff knew how to access, and they also knew where to get accurate advice on the Mental Capacity Act within the provider organisation. Staff we spoke with were aware of the policy and how to access it. Staff we spoke with demonstrated a good understanding of the MCA.

Staff gave patients all support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We observed capacity assessments recorded for patients where there was doubt about their ability to consent to treatment. Staff gave an example of when they used MCA appropriately to treat a patient.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture, and history.

No patients were subject to Deprivation of Liberty Safeguards (DoLS) at the time of our inspection.

## Is the service caring?

Good

This was the service's first inspection. We rated caring as good.

### Kindness, privacy, dignity, respect, compassion, and support

**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, or condition.**

The staff and management team spoke respectfully about the people they cared for. Staff talked of valuing people and respecting the patients' human rights and diverse needs.

Staff were discreet, respectful, and responsive when caring for patients. The interactions we observed between staff and patients were kind and respectful. Patients told us they felt staff treated them with dignity and respect.

Staff gave patients help, emotional support and advice when they needed it. Patients told us they could speak to staff and that they felt listened to and supported.

Staff supported patients to understand and manage their own care treatment or condition. Patients told us they were able to discuss their care and treatment during ward round meetings.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. All patients told us they felt safe on the ward.

Staff understood and respected the individual needs of each patient. They adapted their approach to each individual and worked with patients' individual preferences. Staff worked hard to understand patients' behaviour through debriefs and reflective practice. The psychology team worked with the multidisciplinary team to formulate support plans to enable the wider team to support patients effectively.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients. Staff we spoke to told us they felt safe to raise any concerns if they had to. They were also aware of the freedom to speak up guardian and knew how to access this, should they need to.

### Involvement in care

**Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.**

### Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. The ward had a 'Meet our nurses,' board with photographs of permanent staff on the ward displayed near the ward's reception. All patients received a comprehensive welcome pack on admission. This included the ward's commitment to support patients to make their own choices, work towards independence, and feel good and proud. It had information on what to expect on the ward, including staff roles, mealtimes, medicines management and how to make a complaint or give feedback.

Staff involved patients and gave them access to their care plans and risk assessments. Care plans contained detailed information, were holistic, and showed patient involvement and views, although these were sometimes quite minimal.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. For example, the service engaged the services of a translator to engage with patients who did not speak English during ward round and to read Section132 MHA rights to another patient who could not read English.

Staff involved patients in decisions about the service, when appropriate. Patients attended weekly community meetings and provided feedback on the service. Minutes of these meetings indicated that when patients raised maintenance issues such as issues with their televisions and boiler, the maintenance team addressed the problems quite swiftly. There was a board posted in the patients lounge with information on 'You said, We did,' feedback on requests made by patients and included requests for activities on the ward. The service had just appointed an occupational therapist to the ward, and staff were attempting to facilitate more weekend activities, although staff reported limited interest from few patients when staff approached them.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff made sure patients could access advocacy services, with contact information made available to them as appropriate. For example, patients told staff during community meetings that they were happy with the advocate.

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

Good

### Involvement of families and carers

**Staff informed and involved families and carers appropriately.**

Staff supported, informed, encouraged, and involved families or carers to give feedback about the service. Staff informed us they sought consent from patients who had capacity before involving their family in their care. Staff involved patients who did not have capacity to make decisions through their advocate. Families were sometimes involved in ward through virtually means such as via video calls. The ward also had a dedicated visitors' room where patients met their families.

Staff gave carers information on how to find the carer's assessment, and there was a monthly carers' newsletter, with up-to-date information about the hospital.

## Is the service responsive?

Good

This was the service's first inspection. We rated responsive as good.

### Access and discharge

**Staff managed beds well. A bed was available when a patient needed one and that patients were not moved out of the hospital unless for their benefit. Discharge was rarely delayed for other than clinical reasons.**

### Bed management

The ward had a clear admission policy and criteria for admission that staff followed. Staff discussed all referrals within the multidisciplinary team. At the time of the inspection the service was not taking any patients that required seclusion because the seclusion room was being constructed. Staff told us that if a patient required seclusion, the service transferred the patient to a psychiatric intensive care unit (PICU).

The multidisciplinary team reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay for patients on the ward was 39 days. Where patients no longer required acute services, the team collaborated with commissioners to move patients back to their catchment area. The ward took referrals from all parts of the United Kingdom, most patients were out of area placements.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Staff did not move or discharge patients at night or early in the morning. The service managed all transfers of care to ensure they happened at the appropriate time for the patient and any moves to other units were based on clinical need and in the interest of patients.

### Discharge and transfers of care

Managers monitored the number of delayed discharges. Managers discussed delayed transfers at the senior leadership and clinical governance meetings and tracked the progress of each patient.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. The ward held a weekly multidisciplinary meeting which staff used to plan patient discharges. We observed discussion around a patient's discharge including which discharge pathway was most suitable for them. The service invited patients' families, care coordinators, community mental health and treatment teams to join the discharge planning meeting in person or remotely. The service invited care co-ordinators to attend care programme approach (CPA) meetings prior to discharge.

### Facilities that promote comfort, dignity, and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy, and dignity. Each patient had their own bedroom, which they could personalise and could keep their personal belongings safe. All bedrooms had an en-suite shower. However, we could not inspect the bedrooms because they were all occupied. All bedrooms had a vision panel which staff could control from inside the corridors. There were quiet areas for privacy. The ward was welcoming, with names of staff on shift clearly displayed, as well as the activities for the day.

Patients had a secure place to store valuable possessions within the staff office.

Staff used a full range of rooms and equipment to support treatment and care including a quiet room, therapy room, activities room, and a spacious lounge. The service had quiet areas and a room where patients could meet with visitors or make phone calls in private. Patients were risk assessed to be able to keep their own mobile telephones and a ward telephone was available for patient use. We found the CQC number displayed on the wall for patients to use.

The service had an outside space that patients could access easily. However, at the time of the inspection, the inspection team identified some ligature risks in the garden which made the garden unsafe for patients to use. The service mitigated the ligature risk by restricting access to the garden from 10pm to 7am and for staff to be present when patients used the garden.

Patients could make their own hot drinks and snacks including toast, cereal, and had access to yoghurts and fresh fruits, without being dependent on staff, and we observed patients doing this. Patients told us that the chef offered them a variety of quality food.

Patient discussed the food quality during community meeting and patients told staff they were happy with the food offered. We spoke to nine patients, and they were all happy with the quality of food which they ate the from the kitchen. However, one patient told us the kitchen did not serve a variety of dietary foods.

### Patients' engagement with the wider community

**Staff supported patients with activities outside the service, such as work, education, and family relationships.**

Staff made sure patients had access to opportunities for education and work, and supported patients. The ward offered a weekly programme of activities provided by the newly appointed occupational therapist and his OT team. This included a life skills group, arts and crafts groups, relaxation, and a creative writing group cooking group. Nurses and HCAs facilitated activities in the evenings, such as a movie night and board games.

Staff helped patients to stay in contact with families and carers. For example, the consultant gave patients unescorted leave to go home for overnight stay to be with their families. However, three patients told us they sometimes waited for a long time to have their unescorted leave signed by the registered nurse.

# 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 met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy, and cultural and spiritual support.**

The service carefully assessed and considered each individual referral to the service to ensure the service could safely meet the needs of individuals relating to their disability.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

The service had information leaflets available in languages spoken by the patients and managers made sure staff and patients could get help from interpreters or signers when needed. The service could translate leaflets about how to complain, into other languages if needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. For example, patients had access to menu from which to choose their food. Patients described as flexitarian had access to their choice of food. Patients could make specific requests for foods or menu alterations with ease. However, two patients said there was not enough dietary food on the menu list to choose from.

Patients had access to spiritual, religious, and cultural support. Staff captured information about the spiritual needs of patients when patients filled in their admission forms. However, we identified that patients had access to two bibles and no other religious text to read in the multi faith room. We raised this with the manager who confirmed that staff removed other religious texts from the room following an incident. The service kept other religious texts in the office and gave these to patients when they asked for it.

## Listening to and learning from concerns and complaints

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

Patients, relatives, and carers knew how to complain or raise concerns. Patients we spoke with understood how to make a complaint and told us they would feel comfortable doing so.

The service clearly displayed information about how to raise a concern in patient areas. The patient information pack contained information about how to make a complaint. The service displayed complaint posters throughout the ward.

Staff understood the policy on complaints and knew how to manage them. Staff we spoke to understand the complaints process and supported patients to make complaints and feedback about the service.

Managers investigated complaints, identified themes, and discussed complaints at the monthly clinical governance meetings. Manager shared themes or trends identified was with the wider team.

Staff protected patients who raised concerns or complaints about discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and used the learning to learning from complaints to improve the service. Staff told us the team discussed complaints during handovers, clinical governance, and staff meetings. The service used this information to inform patient care.

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

Good

The service used compliments to learn, celebrate success and improve the quality of care. We saw completed compliment forms praising housekeeping staff for the cleanliness of the ward and compliments about the quality of food provision.

## Is the service well-led?

Good

This was the service's first inspection. We rated well-led as good.

### Leadership

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

Leaders of the ward had experience of working in acute inpatient mental health services. During our inspection, the registered manager demonstrated a good understanding of patients, the staff team and all matters relating to the provision of an acute ward services. The manager was present on the ward and had a good understanding of all the patients' needs and circumstances. The manager told us they received support from an experienced management team at the hospital. Staff said their manager was supportive.

### Vision and strategy

**Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.**

The provider's vision was to provide high quality services through a robust corporate and clinical governance framework. The provider also had a vision to nurture a culture of continuous quality improvement that moves beyond compliance and focuses on delivering excellent care to patients. Managers told us that the service focussed on improving the quality of care for patients and reducing restrictions.

### Culture

**Staff felt respected, supported, and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.**

Most staff said they felt motivated and found the hospital to be a good place to work. Staff described the atmosphere on the ward as friendly and patient centred. Staff also said their team worked well together and respected each other. New staff said they felt welcomed to the ward by the multidisciplinary team. However, one staff said they did not feel valued and did not feel they could raise concerns without having reprisals.

Staff said they felt there had been improvements at the hospital. For example, the provider had recruited and was in the process of recruiting more staff to help improve the staffing levels on the ward. The ward used fewer agency staff which had helped improve safety on the ward. The manager had made improvements to ensure all staff completed their necessary training, and this had improved confidence within the staff team.

The psychologist provided reflective practice sessions for staff, as well as offering additional individual support. Staff attended monthly have your say forum. Staff said the provider held frequent events to celebrate colleague's

achievements. For example, staff celebrated International Nurses Day, the provider relaunched the employee of the month awards. The service provided cooked breakfast once a week to cater for both day and night staff and the provider had planned diversity and cultural food festival for summer. Staff said they felt valued, and that the provider recognised their performance through these celebrations.

Most staff felt that Priory Dorking was a hospital where staff could learn from any mistakes made.

Staff were aware of the organisations freedom to speak up guardian and how to contact them. The manager displayed information about Freedom to Speak Up Guardian in the nursing office. Staff spoke to their manager if they had any concerns about the service. Staff gave examples of when they had raised concerns about care that they gave to patients. Staff said they felt managers acted fairly when investigating incidents and when acting in response to concerns identified during investigations.

### Governance

**Governance processes around medicines and ligature risk management needed improvement.**

The records of quality assurance audits and checks, audit programme around the management of patient safety risks such as ligature risks, and medicines were not robust enough to mitigate against such risks. The provider did not have governance processes in place to enable the systematic review and management of environmental ligature risks at the time of our inspection. We were concerned that the governance around how the management team systematically audited ligature risks and reviewed them were not evident or documented at the time of our inspection. For example, the provider did not have a fully developed environmental ligature risk assessment in the service. We raised these concerns with the management team during our feedback session, and we received assurance of the immediate actions they would take to mitigate the risks.

The management team completed the courtyard garden, all bedrooms and multi faith room ligature audits immediately after our inspection and escalated concerns to senior management and the estate team. The team put systems in place where staff engaged in a robust handover of all changes in mental state and mood in patients during each shift and to escalate any concerns to the nurse in charge and ward doctor/consultant.

The MDT had ligature risk assessment audit as an agenda item on their morning flash meeting on the day of our inspection. We felt assured that the provider had taken the necessary steps to mitigate the ligature risks.

### Management of risk, issues, and performance

**Teams had access to the information they needed to provide safe and effective care and used that information to good effect.**

The hospital collected and analysed data relating to care, treatment, and performance. Managers reviewed this data at monthly clinical governance meetings. This included data about incidents, restrictive interventions, training compliance, meaningful activity, clinical audits, and complaints. Managers reviewed the hospital's risk register at these meetings.

### Information management

**Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.**

For example, the staff completed regular audits of care plans to ensure staff completed care plans in accordance with the hospital's policy. Managers reviewed the results of these audits during clinical governance meetings. However, we identified gaps in the physical health monitoring using NEWS2 charts. Staff used a mixture of paper and electronic recording which led to confusion around escalating risks and keeping records of the frequency of checks conducted by staff therefore putting patients at risk of harm.

### Engagement

**Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.**

The hospital provided national services and accepted patients from across England. At the time of the inspection, most patients on the ward were from Surrey, Norwich, and the Midlands. Integrated Care Boards (ICB) for the hospital's local area functioned as the lead commissioners for the hospital. The local ICB held quality oversight meetings with managers of the service to monitor the performance of the hospital and raise any concerns.

The service engaged well with patients, carers, and staff to help them plan and manage the way the service operated. Staff had participated in the annual Priory staff survey in April 2023. The service had developed and implemented an action plan in response to the service and was addressing areas such as celebrating success and achievements, staff not able to take sufficient breaks.

### Learning, continuous improvement and innovation

The hospital management team were committed to continuous improvement of the service. There was a focus on recruitment and retention and providing training for staff on how to use the newly built seclusion facility. Managers told us they were in the process of implementing 'Safewards' policies within the service and share lessons learnt.

The service was refurbishing the old kitchen to use it as a therapy kitchen.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Diagnostic and screening procedures | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The provider did not ensure that all ligature risks were managed well in the garden and multi faith room and that there were clear plans in place to remove or mitigate against such risks.<br><br>The provider did not ensure staff completed the necessary physical health monitoring for patients who received medicines by intramuscular rapid tranquilisation, to protect patients from significant physical health deterioration.<br><br>The provider did not ensure that staff used one system of recording to record weekly National Early Warning Signs (NEWS2) scores of patients. This process could help staff to detect a patient whose physical health was deteriorating so that staff could quickly escalate any serious concerns to the clinical team.<br><br>The provider did not ensure that there were robust systems in place to check medicines and medical equipment to ensure all out of date items are detected and disposed of. |