# The Priory Hospital Hayes Grove

## Quality Report

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Date of inspection visit: 9 and 10 November 2015
Date of publication: 04/05/2016

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

## Ratings

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

# Summary of findings

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

## Overall summary

We rated Priory Hayes Grove as **Requires Improvement** because:

- Safe systems were not in place to monitor stock medications used within the hospital. Staff were not monitoring the transfer of medications from the stock cupboard on Lower Court to other wards in the hospital. The lack of accurate records meant there was no clear audit trail for this medication.
- The risk assessments on the acute ward, which were being completed as part of the assessment and care planning process, were not comprehensive. When risks were identified there was no clear management plan to minimise risk and ensure that this was incorporated into the care given to patients.
- The provider had not ensured that staff had the skills and support to provide care to patients with complex health and care needs that were admitted to the hospital. It had not provided specialist training to equip staff with the skills to meet the needs of patients with substance misuse problems, eating disorders and autistic spectrum disorders. Also the provider did not ensure that staff working in the eating disorder service received regular individual supervision.
- Although there were designated safeguard leads, when people who used the service on Lower Court disclosed allegations of historical physical or sexual abuse, these concerns were not reported to the local authority responsible for safeguarding. In addition, there was no robust audit of safeguarding alerts to ensure these had been appropriately and referred to the local authority.
- The provider had not ensured that patients' privacy, dignity and safety was maintained through the provision of same sex accommodation. Although patients had ensuite bathrooms and toilets, the bedrooms were not separated as far as possible into male and female zones.

However:

- The Priory Hayes Grove Hospital was providing a service where patients felt respected, listened to, safe and supported.
- The culture and staff morale was positive and staff told us that they enjoyed working at the hospital and caring for people who use the services.
- Patients had access to a range of appropriate therapeutic interventions.
- We were told that patients thought the food, which was cooked on site, was very good.
- There were good levels of staffing across the hospital, which meant that patients received their care and treatment in a timely manner.
- Most incidents were reported and there was learning from these incidents.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Acute wards for adults of working age and psychiatric intensive care units** | Requires improvement  | We rated acute wards for adults of working age as requires improvement because:<br>Some medicines management was not robust as there was no system in place to ensure medicines which were transferred between wards were tracked.<br>Male and female bedrooms were not separated as far as possible into zones to maintain the privacy, dignity and safety of patients.<br>Risk assessments were not always completed in a robust manner and incorporated into the individual care plans.<br>Safeguarding issues raised by patients were not always being referred to the local authority in line with safeguarding procedures.<br>Many of the patients using the service were being supported with their substance misuse. Staff had not had training in this area and needed support to develop these skills.<br>However:<br>Patients told us that they were treated with care and dignity. The ward staff ensured that people's care was delivered in a clean hygienic environment. Patients had access to a range of therapies and activities over six days a week and the effectiveness of therapies was measured |
| **Wards for people with learning disabilities or autism** | Good  | We rated wards for people with learning disabilities as good because:<br>Patients felt supported, cared for and respected by staff on the ward and had their individual needs met.<br>There were sufficient staff and the ward environment was clean and safe.<br>Patients had access to support with their physical health.<br>There were a good range of therapeutic activities available and staff encouraged the patients to get involved.<br>However: |

# Summary of findings

Specialised training to work with people with autistic spectrum disorders was not provided for staff working in the service.
The communal space in the ward was small and this could compromise people's privacy and dignity.

## Specialist eating disorders services

Requires improvement 

We rated specialist eating disorders services as requires improvement because:
Staff were not routinely accessing individual clinical supervision to support them in their roles and development.
Specialised training to work with people with eating disorders was not provided for staff working in the service.
Male and female bedrooms were not separated as far as possible into zones to maintain the privacy, dignity and safety of patients.
However:
It provided supportive and caring treatment programme for patients with severe eating disorders.The service was able to support people with challenging conditions, and for many patients whose treatment had failed in other settings.
The unit had successfully treated several patients who had been admitted with life threatening presentations.
The environment was clean and comfortable and the staff were dedicated, enthusiastic and had high morale.
The high quality of leadership shown by the two consultants was referenced by both staff and patients.

# Summary of findings

## Contents

Requires improvement

# The Priory Hospital

**Services we looked at**

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

Wards for people with learning disabilities or autism

Specialist eating disorders services;

# Summary of this inspection

## Background to The Priory Hospital Hayes Grove

The Priory Hayes Grove is an independent hospital that provides support and treatment for people with mental health needs, eating disorders and drug and alcohol addictions. It has 46 inpatient beds. It provides care and treatment for men and women aged between the ages of 18 and 65. The services provided include acute mental health inpatient care, addiction therapy, and specialised inpatient care for people with eating disorders and for people with autistic spectrum disorder who also have mental health needs. Priory Hayes Grove provided the following services:

Lower Court is an acute admissions ward for 17 men and women. People on the ward receive treatment either for their mental health needs or through the Priory addictions programme.

The eating disorders service has 20 beds and consisted of two wards with three phases of treatment. The eating disorder acute ward and the progression and transition ward each have 10 beds. Admission and assessment takes place on the acute admissions ward. The progression and transitions ward is focussed on moving towards recovery and discharge planning. There is a programme of individual and group therapies across both services.

Keston Unit is an inpatient ward for people with a diagnosis of autistic spectrum disorder who required inpatient support and hospital facilities. It was a mixed gender ward for adults of working age.

The hospital also delivers a therapy service at the Cedar therapy centre that provides counselling and therapeutic interventions for patients in the inpatient services at the Priory Hayes Grove. The Cedar therapy service also provided counselling and therapeutic interventions for patients on an outpatient basis.

The hospital was meeting all of the regulatory standards at a previous inspection in October 2014. The provider was registered to provide care for the following regulated activities:

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

## Our inspection team

The team that inspected the Priory Hayes Grove consisted of two inspection managers, five inspectors, two specialist advisors, a Mental Health Act Reviewer, and one expert by experience. The experts by experience are people who have developed expertise in health services by using them.

## Why we carried out this inspection

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

# Summary of this inspection

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients, carers and staff through comment cards. This included feedback from four commissioners of service, one local authority and one care co coordinator

During the inspection visit the inspection team:

- Visited all three wards of the hospital and looked at the quality of the environment
- Spoke with 17 patients who were admitted to the wards and four carers
- Collected feedback from staff, patients and carers/ relatives through comment cards
- Spoke with senior managers of the service and the three ward managers
- Spoke with13 members of staff, including the ward managers, nurses, health care assistants three consultant psychiatrists, the medical director, the pharmacist, a student nurse and an assistant psychologist
- Observed how staff were caring for patients and observed two ward round meetings and a clinical handover meeting
- Observed lunch time on the acute inpatient eating disorders ward, observed a community meeting on an eating disorder ward and observed ward based activity
- Carried out Mental Health Act monitoring visits on Keston Unit and the eating disorders service
- Looked at a range of records, policies and documents relating to the running of the service and reviewed the supervision records of staff
- Reviewed 28 patient care records, 4 complaints from the past 12 month period and five incidents reports of restraint
- Reviewed 25 medication charts across the three services
- Spoke with the training and development lead from the human resources department, the lead for quality improvement, the compliance officer, the lead for safeguarding and the manager of Cedar day therapy services

## What people who use the service say

Overall, the feedback from patients was that staff were kind, respectful, caring and that the environment was clean and comfortable.

On Lower Court, patients we spoke with during the inspection visit gave positive feedback about their experiences on the ward. Patients told us that staff treated them with dignity and respect and that they were given the opportunities to access varieties of therapy and activities while on the ward and were positive about the food.

On the eating disorders wards, patients we spoke with said that they felt safe on the unit. They said that staff were kind and respectful and were supportive in helping them try to recover. Patients said that the staffing levels were good but one patient said that the nurses sometimes did not communicate well with each other. However, there were also complaints from some patients that staff working on the eating disorders service were dismissive. All the patients said that the quality of the food was good but two patients were critical of the lack of support at mealtimes and immediately afterwards. Four patients spoke very highly of the consultants on the wards and said that they were the driving force for treatment and decision making. All the patients liked the therapeutic programme though one patient said she found it very difficult to engage in groups and one patient said that there was not enough focus on psychological therapy. Patients said that they liked their rooms and were able to personalise them. They said that they

# Summary of this inspection

received copies of their care plans but one patient said that all the care plans were the same. Patients said that there was little space on the wards but that they did like the garden area. Patients said that their families were kept involved in their care during admission. One patient said that she found it very upsetting having to see other patients restrained on the ward.

On Keston Unit, patients we spoke with said that the staff were respectful, kind and listened to their concerns. Patients on Keston Unit also told us that they often felt frustrated by the high levels of close observation.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- Staff were not monitoring the transfer of stock medications from Lower Court to other wards in the hospital, opening up the possibility of medicines management errors across the hospital.
- Male and female bedrooms were not separated as far as possible into zones to maintain the privacy, dignity and safety of patients.
- Individual risks for patients in Lower Court were not thoroughly assessed or recorded. The lack of thorough risk assessments meant that the management of risk was potentially not being recognised and addressed during patient care.
- Disclosures of allegations of historical sexual abuse from patients on Lower court were not being treated as safeguarding issues. These allegations were not identified as safeguarding concerns and were not referred to the responsible local authority for follow up. Safeguarding concerns and alerts were not robustly monitored within the hospital.

However:

- The ward environments within the hospital were clean, hygienic and comfortable.
- The ward had a rota that ensured the housekeeping staff cleaned the ward regularly.
- Across the three services staffing numbers were sufficient to meet the needs of the patient group.
- Staff were aware of how to report incidents. There were examples of learning from incidents, which had occurred.
- There was appropriate monitoring of patients and physical health checks were taking place after restraint.

### Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Staff were supporting patients with complex needs but had not had the specialist training to enable them to carry out these roles. This included training in substance misuse, eating disorders and autistic spectrum disorders.
- On the eating disorders service staff had not received regular individual supervision.

# Summary of this inspection

- Patients who were detained under the MHA did not routinely have access to an Independent Mental Health Advocate (IMHA).
- Physical health care plans and recordings of physical health checks were occasionally not completed on Lower Court.
- Audits were taking place but where they highlighted areas for improvement action plans were not always in place.
- Staff were not routinely assessing capacity to consent to treatment particularly on Lower Court
- There was no allocated psychologist working in the eating disorders service, which meant that people who used the service accessed psychological support from the Cedar therapy centre

However:

- Patients had access to a range of therapies recommended by NICE guidelines and patients reported positively on the experience of receiving therapy.

## Are services caring?

Good

We rated caring as **good** because:

- Patients we spoke with told us that staff were kind, considerate and respectful and involved them in their care.
- Feedback we received from patients indicated that Priory Hayes Grove was a friendly, caring environment
- Staff showed a good understanding of the individual needs of patient, although some care plans did not demonstrate a consistently holistic approach to care, particularly on Keston Unit
- Patients had access to advocacy services when required and could access the service promptly. The advocacy service Voiceability was used by the hospital and was regularly involved in the review and planning of care for patients in the services.

However:

- On Lower Court patients were not always involved in their care planning and this lead to a lack of individualised person centred care.
- The quality of interactions between patients and staff where people were being closely observed, on the ward for people with autism spectrum disorders could be improved.

## Are services responsive?

Good

.We rated responsive as **good** because:

# Summary of this inspection

- Lower Court which provided acute inpatient beds was spacious, welcoming and offered a good therapeutic environment.
- There was a good addictions therapy programme in place in Lower Court, which included individual therapy, group therapy, activity groups, relaxation and mindfulness as well as yoga sessions.
- There were opportunities for patients to personalise their bedrooms on the eating disorders service, which helped to create a sense of belonging and personalisation for patients who may be in hospital for long periods of time.
- The complaints system in place was working well and patients were aware of how to make complaints and reported that complaints were responded to quickly.

However:

- There was limited space in the communal area on the Keston Unit meaning that people who used the service could have their privacy compromised.
- Across the hospital environment there was no designated area to meet the religious/spiritual or cultural needs for people from different backgrounds.
- On the ward for people with autistic spectrum disorders there was the potential to do more to support people to plan for their discharge.
- On the eating disorders service there was no designated space for individual therapy sessions to take place

## Are services well-led?

Good

We rated well-led as requires **good** because:

- Staff had confidence in their ward managers and felt supported by them, reflecting a culture of support and respect.
- The services were well led at ward level and by the hospital director and there were good governance processes in place. For example, staff completion of mandatory training was monitored to ensure staff were up to date.
- Overall, there was good staff morale within the hospital and staff felt valued. On the eating disorders service low morale amongst some staff had been recognised and the service was working actively with staff to respond to their concerns and make changes.

# 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.

The hospitals systems supported the appropriate implementation of the Mental Health Act and its code of practice. Detention paperwork was filled in correctly, was up to date and was stored appropriately. There was a Mental Health Act administrator based on site. Staff knew how to contact them for advice where necessary.

Training on the Mental Health Act and the Mental Capacity Act was covered as part of the mandatory training. People who used the services had their rights under the Mental Health Act explained to them routinely.

The main area for improvement was in relation to adherence to consent to treatment and capacity requirements.

We found that staff were involved in auditing mental health act compliance on a ward level.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act (MCA) awareness training was delivered to all staff as part mandatory training programme, and the hospital had an identified member of staff who was the lead for mental capacity act awareness.

Although most staff across the wards had completed training in the Mental Capacity Act (MCA), their knowledge of the MCA was variable. There was variation in practice of ensuring that capacity to consent to aspects of ace and treatment were adequately assessed across the wards.

Application for Deprivation of Liberty Safeguards (DoLS) were made where required and this was consistent across all the wards. This meant that where restrictions were present in a person's care, appropriate consideration and relevant application to safeguard the persons had been made.

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

Requires improvement

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

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

Requires improvement

### Safe and clean environment

- Lower Court accommodated up to 17 patients. It was an open ward, which did not have a locked door so patients were able to move around the building and access the garden when they wished to. There were potentially areas in the ward where there would be blind spots. However, this was mitigated by the ward observation policy and individual risk assessments which were carried out on admission by the multi-disciplinary team.
- Rooms were not ligature free and there were areas in the ward where there were ligature risks and ligature anchor points available. Regular observation of patients by nursing staff mitigated this risk. The constraints of the environment were a part of admission assessments when ascertaining whether the ward was suitable to meet individual needs.
- Bedrooms were ensuite with a shower, toilet and sink. There was a bath available off the ward. Bedrooms were not allocated differently according to gender with men and women allocated to rooms based on their needs. This meant that there was no specific 'zoning' of male and female bedrooms.
- The ward had a clinic room which had accessible emergency equipment including resuscitation equipment, a defibrillator and emergency medication which was easily accessible and checked weekly. There were ligature cutters and staff knew where they were. There was a couch in the clinic room which was available to be used for patient examination when necessary.
- The ward area was clean and hygienic. Patients reported to us that the environment was clean.
- There was a wall based alarm system in place on the ward for patients and visitors to call for assistance. Staff had personal alarms in addition on this to ensure staff safety.

### Safe staffing

- The establishment staffing numbers for Lower Court was adjusted based on the numbers of patients on the ward. When there were 13 or fewer patients, there were two nurses and one health care assistant during the day and one nurse and two health care assistants at night. When there were more than 13 patients, an additional health care assistant was assigned to the ward at night.
- There were no staffing vacancies on the ward at the time of our visit.
- There were medical staff on call 24 hours per day and there was a safe level of medical cover.

### Assessing and managing risk to patients and staff

- There had been no incidents of restraint or seclusion in the six months prior to the inspection visit.
- Risk assessments were carried out before admissions by the nursing staff and doctors. These risk assessments were reviewed during inpatient stays. We checked the records of four patients. One of these risk assessments had not captured significant information about a patients' physical health. This had not affected the care

that was provided and nursing staff were aware of the physical health needs of patients. However, this was not recorded clearly which meant that there was a risk that this information may not be shared or used by all staff. Two patients' risk assessments stated that there were risks of self-harm or suicide but did not specify the manner in which these risks presented themselves and it was not clear in case records what the level of risk was for these patients. This meant that information that would be important to capture to determine the risk in the environment or the levels of observation needed was not recorded so may not be mitigated.

- All patients had a physical health check on admission. The ward used modified early warning signs (MEWS) framework to record information about physical health checks.
- At the time of our visit, no patients were detained under the Mental Health Act. The ward was open with no locked door.
- Staff had undertaken safeguarding training. Three members of staff we spoke with told us that they would contact the safeguarding lead or managers if they had safeguarding concerns. There was information in the staff office with contact details for the local safeguarding teams. However, we found that when patients disclosed allegations of historical sexual abuse on Lower Court, these disclosures were not treated as a safeguarding issue. Staff on the ward following these disclosures, did not make a safeguarding alert. This meant that sharing of the information regarding these allegations with the local authority responsible for monitoring this type of information and risk, was not taking place. The Priory Group safeguarding audit took place on an annual basis and the hospital was required to submit information for this audit. However this had not identified that safeguarding alerts had not been raised.
- Medicines were stored in the clinic room. The clinic room on Lower Court had a large storage area and stock medicines for the other wards in the hospital were stored in this clinic room. The clinic room on Lower Court also had the only controlled medicines cupboards of the hospital located in it. Controlled medicines were stored and checked appropriately. An independent contractor carried out the pharmacy role and they were responsible for weekly auditing. We saw that this was completed. However, there was no system in place to monitor medicines transferred between wards. This meant that there was the risk that medicines management errors may occur.

**Track record on safety**

- Between March 2015 and September 2015, there were four serious incidents which required investigation. These incidents included a patient who left the ward and was subsequently found to have died. All of these incidents were reported and investigated properly.

**Reporting incidents and learning from when things go wrong**

- There were four serious untoward incidents reported on Lower Court between April to September 2015. There was an online incident recording system but also a paper system. The ward manager, when reported of incidents reviewed the incident with ward staff.
- In the ward office, there was an incident log so that information about incidents was available to all staff. This meant that when staff reported incidents, they could follow how they were resolved.
- Incidents in the ward and in the hospital were discussed at staff team meetings.
- The hospital demonstrated that it was using the learning from incidents and making changes where needed. For example, one incident had occurred when a patient had not contacted their home crisis team on discharge when they had relapsed. Following this, as a learning point, all patients were given clearer information about contacts in a crisis on discharge. A daily handover meeting between ward staff and day therapy services staff had been established to discuss individual patient progress and share information regarding levels of risk. This had taken place following a recent serious incident.

**Duty of Candour**.

- The hospital was not providing training on Duty of Candour for staff on Lower court. However staff we spoke to understood the principles of duty of candour and were aware of what steps to take to speak with a service users if a mistake or incident occurred.

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

Requires improvement

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

(for example, treatment is effective)

Requires improvement

### Assessment of needs and planning of care

- Patients had up to date care plans which were reviewed regularly. Patients had care plans linked to their mental health needs or needs relating to their substance misuse.
- Patients who were on the ward due to their substance misuse needs, had a clear programme which was given to them at the start of their admission which included the expectations and commitments of the service. So while there were not always clearly identifiable individual and holistic care plans, patients on the ward who were following this pathway, had a good understanding and knowledge of the care they were receiving while on the ward.
- We saw mixed examples of physical health care plans with some good and clear plans. One patient did not have a care plan that addressed their physical health needs. Another had a thorough plan that addressed their specific needs such as their hypertension. The hospital used both a paper and electronic record to update information about patients' care and progress. The ward manager had developed a new system, which was embedding during our visit where information and feedback from ward rounds was captured immediately on paper and then collated so that it was not lost.
- The ward had eleven admitting consultants, which meant that there could be an inconsistency in working practice. To address this a protocol to collect information from ward rounds had been developed, to ensure consistency and better communication in general.
- An assistant psychologist from the hospital therapy centre attended ward rounds in order to share information between the wards and the therapists. This helped with communication and the staff considered this to be a positive development.

### Best practice in treatment and care

- The service considered both the Maudsley and NICE guidelines when prescribing medication.
- There was a full therapy programme available for patients over six days (Monday to Saturday). This included cognitive behavioural therapy, dialectical behavioural therapy skills, gender specific support groups and mindfulness/relaxation groups.
- Patients had access to physical health care provided by the doctors on site but also had access to referrals for primary and secondary physical health care services as required. The ward had a good working relationship with the local acute hospital and arranged for transfers and appointments when necessary.
- The hospital had an audit programme which was carried out on a rolling annual basis. This allowed some clinical audit work to be completed on the ward. For example, there was an annual audit regarding depression and ensuring that NICE guidelines were followed.
- The hospital was conducting 12 annual divisional audits in line with the provider strategy to ensure that quality and safety of services were maintained. The compliance officer was responsible for overseeing the completion of audits and subsequent action plans. Audits of risk assessments, observations of patients and care plans had been completed on Lower Court. This showed that risk assessments were not incorporating service user discussion and that the risk assessments did not have a management plan that addressed the identified risks. In addition, the audit highlighted that risk had not been discussed in the ward multi-disciplinary team meeting. Action plans and follow up measures to address the findings of the audit were not in place.

### Skilled staff to deliver care

- The ward team consisted of medical and nursing staff. Therapists provided therapeutic input through individual and group work which took place both on and off wards. There was one assistant psychologist who attended all ward rounds and therapy staff meetings. A pharmacist visited the ward weekly and completed medication audits. They did not attend ward rounds. However, they were part of the clinical governance meetings across the site.

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

Requires improvement

- Staff received a corporate and local induction when working on the ward. We spoke with one member of staff who had recently joined the ward team and they told us that the induction was both ward based and involved e-learning and felt it was sufficient to have an understanding of the needs of the ward.
- Specialist staff with appropriate knowledge and expertise to support and treat people with substance misuse problems were not employed on the ward. Staff did not have specific training related to understanding substance misuse treatment and care. However, there was information available on the ward and written material was shared with people using the service about the substance misuse care pathway.
- Staff told us that they received regular supervision. We looked at supervision records. A new manager had recently been employed who had developed a chart which ensured that supervision was completed and offered in a timely manner. Staff told us that they felt supported in this.
- Across the hospital 96% of staff had received an appraisal.

**Multi-disciplinary and inter-agency team work**

- Ward team meetings took place on a monthly basis. We saw minutes from these meetings. They included issues, which were relevant to the ward specifically, as well as issues relating to broader clinical governance across the site, including complaints and incidents.
- Nursing staff operated on a 'long day' system where there were two shifts over a 24 hour period, a day shift and a night shift. This meant that there were two handovers per day, in the morning and in the evening. Handovers were recorded and there was a file in the staff office, which held handover notes. Each patient and the current risk levels were discussed at handover meetings.

**Adherence to the MHA and the MHA Code of Practice**

- At the time of our inspection, there were no patients who were detained under the Mental Health Act.
- There was a Mental Health Act administrator on site who staff were able to approach with queries if any arose, which related to the Mental Health Act.
- There was a copy of the current Mental Health Act Code of Practice in the ward office, which meant that it was accessible for staff to use.
- Mandatory training provided an awareness of the Mental Health Act and the Mental Capacity Act.

**Good practice in applying the MCA**

- The ward manager of another ward was a hospital lead on mental capacity and Deprivation of Liberty Safeguards across the hospital. Staff were aware they could ask for support if they required this.
- In two of the records we checked, we saw that capacity to consent to informal admissions had been recorded. Patients who were receiving support for substance misuse completed contracts on admission which assumed capacity to consent unless there were specific circumstances where this may not be the case.
- For one patient admitted to the ward for treatment for their mental health problem, there was no recorded assessment of the person's capacity to consent to an informal hospital admission. This record also stated that the patient "has been informed [they are] not to leave without consent from [their] doctor or nurse in charge". As capacity to consent to an informal admission had not been recorded, there was the risk that they may be subject to the restrictions of someone who was detained.
- We observed a daily handover between day therapy service and the clinical staff on Lower Court. During this handover, concerns around a patient's choice not to take a prescribed medication were discussed. The assessment of capacity to make this choice was not discussed in relation to this patient.

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

Good

**Kindness, dignity, respect and support**

- We observed nursing and medical staff provided care and support in a friendly and approachable manner.

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

Requires improvement

- Four patients who we spoke with told us that they felt safe in the service and were positive about staff support.
- Staff we spoke with had a good understanding of the individual needs of patients.

**The involvement of people in the care they receive**

- The ward staff provided patients with information on admission including a ward information and welcome pack, which included information on how to make complaints and information about the treatment being provided.
- There was a board with photos of all the staff, and their names, which was clearly on display in the ward and would help to orientate patients to the ward team and have an understanding of the different roles of staff members.
- We did not see evidence of patients' involvement in care planning in the records. Patients who were on the addiction pathway had a clear care plan, which they were given before their admission to the ward. Patients told us that they understood their care plans but their involvement was not clearly documented.
- There were weekly community meetings on the ward. We saw the minutes from these meetings that were documented and action was taken based on these meetings. For example, weekend activities including yoga were added as a response to patient requests.
- Patients completed a discharge questionnaire following admissions, which helped the ward to collate specific feedback about the experiences of patients on the ward.

**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**

- At the time of our inspection, all patients on the ward were privately funded. People who used the service either self-referred or were referred via their GP or other healthcare teams.
- Between October 2014 and the end of September 2015, the average lengths of stay for patients on the addictions pathway was 25 days, 8 days for patients on the detox pathway and 17 days for patients with acute mental illness. These average lengths of stay were in line with standard or expected practice.
- No discharges were delayed at the time of our inspection visit.

**The facilities promote recovery, comfort, dignity and confidentiality**

- The ward was spacious with a number of rooms, including a women's lounge, a general lounge and a kitchen. The kitchen was open which ensured that patients on the ward had access to food and drinks, both hot and cold, during the day and at night.
- There was a garden area accessible to patients on the ward. This had a smoking shelter. The hospital did not have any plans to move towards being a smoke free environment.
- Patients we spoke with gave us positive feedback about the quality and choice of food available. The hospital had a dining area that was located away from the ward. Menus were available on the ward and there were choices available for different dietary needs including gluten free diets and vegetarians. The service was able to cater for other menu options such as halal or kosher food.
- The ward had a schedule of activities and therapy groups, which ran over six days a week. This included art, fitness and exercise groups as well as walks in the local community.

**Meeting the needs of all people who use the service**

- Staff told us that they were able to access interpreters as required.
- Information was available in the ward area about treatments and managing both mental illnesses and addictions. The ward had access to information sheets about medicines, which were given to patients on demand. These were also available in different community languages.

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

Requires improvement

- The ward was based on the ground floor and there was one room that was accessible for people who may have mobility difficulties, which had a wet room. Staff could order hoist equipment when necessary and told us that they had done this in the past.

**Listening to and learning from concerns and complaints**

- There were nine complaints received in the past twelve months. Five of these complaints were upheld. None of these complaints were referred to the ombudsman.
- The hospital had an established complaints handling procedure. The ward manager was aware of the complaints policy.
- There was information available on the ward for patients to let them know how to make both formal and informal complaints within the service.
- The hospital collected information about formal complaints centrally, which was available at a ward level. Feedback from complaints was shared at ward level in team meetings though staff we spoke to were not able to give examples of changes or learning taking place following complaints.
- The ward manager had a complaints log, which was kept in the ward office where informal complaints were collated. Patients were given complaints forms to complete when there were concerns which were raised. These were managed informally as a first response but patients had access to formal complaints processes if required.
- One patient told us that complaints were dealt with quickly.

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

Good

**Vision and values**

- Staff we spoke with told us that they were proud to work for the hospital and the organisation. They were able to reflect the values of The Priory Group.
- Staff were very positive about the hospital director and the senior management team within the hospital. They told us that they were very visible and approachable. Staff on the ward told us that they felt supported by their managers.

**Good governance**

- A governance system was in place in the hospital. There were a number of meetings across the hospital where information was shared and discussed and these fed into overarching clinical governance committee led by the provider. We reviewed the minutes for these meetings, which showed that information sharing took place well within the hospital and the wider organisation.
- Senior management team meetings were taking place on a monthly basis. Issues from ward and patient meetings were discussed. Serious incidents, risk register, recruitment and rolling organisational issues were also discussed at this meeting.
- The 'your say forum' provided an opportunity for staff to feedback and raise concerns which were discussed at the senior management meeting.
- There had been a recent change in the ward manager on the ward. The new ward manager had come from a different organisation and had made some changes in processes to improve communication and information sharing on the ward. For example they were recording ward rounds in more thoroughly and logging supervision and training on the ward. Some of these systems were in the process of embedding, so some of the ward round notes were not completed fully. This was a continuing process.
- Issues of risk and patient safety were being considered at the medical advisory committee. This ensured that close medical input into patient safety and risk occurred and learning took place across the hospital.
- A risk register was present with action plans to address risk across the hospital. The risk register was discussed regularly at senior management team meetings.
- The hospital completed 'quality walk rounds' regularly to capture patient experience, staff experience and look at the environment. The outcomes were fed back to staff at ward level so they could make improvements as needed.

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

Requires improvement

**Leadership, morale and staff engagement**

- Staff were positive about the ward and the atmosphere on the ward. They told us that they were aware of the local whistleblowing policies and felt able to raise concerns as necessary.
- Staff we spoke with told us that they have opportunities to develop professionally within the group. One member of staff told us that they were supported in their career development by the organisation.
- A new manager had been appointed to the ward. Staff feedback was that they were approachable. The team morale was good and there was a settled staff team.
- The hospital had a practice development nurse who focused on supporting newly qualified nurses through preceptorship and ensuring their medication competencies.

**Commitment to quality improvement and innovation**

- The ward manager and staff on the ward displayed a commitment to continuous improvement and reflecting on their current practice to make improvements.
- The hospital carried out internal inspections to identify areas for improvement and the practice development nurse role ensured that best practice was disseminated.
- The hospital had set quality improvement objectives with timeframes for completion. The senior management team was monitoring these objectives.

Good

# Wards for people with learning disabilities or autism

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

## Are wards for people with learning disabilities or autism safe?

Good

### Safe and clean environment

- The ward was located on the ground floor of the hospital. The ward was clean and well maintained. There was a small communal lounge, which patients could use for activities, dining or for relaxation. Patients and relatives told us that they found the communal area comfortable. There was a small garden leading out from the communal lounge.
- Although there was a large garden on the hospital grounds, most patients accessed the smaller garden space adjacent to the communal lounge on the ward.
- The unit had a number of ligature risks, including taps on the ward and metal bars outside the windows. Staff identified these risks through ward-specific ligature audits. Patient bedrooms were refurbished two years ago and contained anti-ligature furniture, for example light fixtures and desks. Each bedroom had individual ligature audits that were stored within each patient folder. Together with individual patient observations, this served to mitigate risk
- Staff managed risks such as deliberate self-harm by providing an appropriate level of observation with suitable care plans. For example, for patients with particular ligature risks, staff documented the visibility of personal items such as hair dryers, laptop chargers and headphones throughout the duration of one-to-one observations. Ligature cutters were available and staff were aware of their location.
- All bedrooms were single with ensuite facilities. Patient bedrooms were located along the same corridor. At the time of inspection, there were seven male and two female patients. Female bedrooms were located in the middle of the corridor opposite one another.
- Patient's privacy and dignity may have been compromised at times. For example, the doors of patient bedrooms were required to remain open during one-to-one observations. This meant that other patients and staff members walking along the corridor were able to see clearly into patient bedrooms. The ward had a small female lounge, which was also used for interviews and as a quiet area due to the lack of space on the ward. This also meant that there was a risk of compromising the privacy and dignity of patients using the female only lounge.
- The clinic room on the ward was very small and stock medicines were stored in the clinic room on Lower Court.
- A cleaning schedule was present and updated regularly. Handwashing facilities were available in the ward areas with visible posters on handwashing technique. Alcohol gel sanitisers were accessible near the sinks and at the entrance of the ward.
- Keston Unit had alarm systems mounted on walls and staff carried personal safety alarms. These worked and were operational.

### Safe staffing

- The hospital set minimum staffing levels for Keston Unit. For the day shifts, this comprised of two qualified nurses, supported by two health care assistants. For the night shifts and weekend shifts, minimum staffing levels consisted of one qualified nurse, supported by two health care assistants. The ward had no vacancies for both qualified and unqualified staff.

Good

# Wards for people with learning disabilities or autism

- The ward manager was able to request additional staff if required based on the needs of people who used the service. For example, the ward used bank staff to cover the close observations of patients who were most at risk. The ward increased the number of nurses and health care assistants when patients required close observations, and when staff were attending training. Use of agency staff was low with three occasions of agency staff use during October 2015.
- At the time of inspection, 3 out of 9 patients had regular escorted leave into the community. Escorted leave took place as planned, without any last minute cancellations due to staff shortages.
- There was a good level of medical cover during the day and at night to meet the needs of patients. Two doctors worked Monday-Friday (09:00 - 17:00) across Keston Unit and Lower Court. One doctor was available across the hospital out-of-hours and stayed on-site overnight.
- Mandatory staff training completion rates at the Keston Unit was 97.5%. Staff completed mandatory training in prevention and management of violence and aggression (PMVA). The hospital provided PMVA training through face to face sessions led by expert instructors, combined with mandatory online modules as part of the foundations for growth (FFG) training package. Staff informed us about opportunities to become PMVA trainers within the hospital after completing relevant training via the national federation for personal safety.

**Assessing and managing risk to patients and staff**

- There was no practice of seclusion on the ward.
- A dedicated compliance officer reviewed the recorded incidents of restraint on a weekly basis. There were ten incidents of restraint involving three different patients over the six months preceding the inspection. During September 2015, there was one out of two incidents recorded as an episode of restraint. During November 2015 one out of three restraint incidents involved to patient on patient violence.
- There was an inconsistency of how restraint was being recorded in incident forms. Out of five incident forms reviewed for November 2015, none referred to the restraint of a patient. However there was one incident of restraint in November 2015 which was not recorded as an incident in the incident recording process.
- Staff were able to provide examples of incidents that demonstrated the use of verbal de-escalation techniques prior to restraint. Staff had not restrained any patient in the prone (face down) position in the last year.
- Staff had completed individual patient risk assessments in all five care records we reviewed. Staff explored the risks that patients posed to themselves, staff and others. Staff developed care plans to mitigate these risks, for example through close observation of patients. Staff reviewed and updated risk assessments regularly. When significant incidents occurred, they were reported to the ward manager and there was further discussion around risk management at handover meetings.
- Staff completed risk assessments before patients left the ward to go on leave and recorded and documented the outcome of leave in the care records.
- Staff documented patient risks on a white board in the nursing office. Information included the type of risk such as risk of self-harm, status of detention under MHA, and categorisation of nursing observation levels. Staff used a red, amber, and green risk rating that indicated the frequency of observations for each patient.
- There were some blanket restrictions in place on Keston Unit. For example, the hot drinks machine in the lounge area was kept switched off. Patients were required to ask staff to turn on the hot drinks machine if they wanted tea or coffee. Staff informed us that this was in place due to risk of uncontrolled excessive drinking by some patients and this restriction formed part of a harm minimisation strategy.
- At the time of inspection, four patients were categorised as informal. Two out of the four patients were waiting for assessments following an application to authorise a Deprivation of Liberty Safeguard (DoLS) under the Mental Capacity Act 2005. Between August and November 2015, there were three incidents of patients absconding where patients left the ward or garden without informing staff. Informal patients were able to leave the ward when they wanted and were not restricted. Staff or family members often accompanied informal patients outside of the hospital.
- Staff received training in safeguarding. Staff had a good understanding of safeguarding processes and knew how to access support when necessary through the designated hospital safeguarding leads. Posters and flowcharts on safeguarding were displayed on walls,

and safeguarding policy folders containing information guiding staff in making referrals were easily accessible on the ward. Safeguarding leaflets for visitors and volunteers were available from reception. Staff followed procedures in relation to children visiting the ward.

- Good medicines monitoring and management were in place on the ward. We reviewed the medication administration records of nine patients were reviewed. There were no missing signatures on the records, allergies were recorded, and refusal of medication was appropriately documented. Pharmacists reviewed medication charts on a weekly basis, and they ensured medicines were dispensed, administered and audited effectively.
- All medicines were stored correctly and transported securely. Controlled drugs were stored in Lower Court, and were monitored in accordance with legal requirements

**Track record on safety**

- Between June 2014 and November 2015, there were three serious incidents which required investigation across the hospital. One of these took place on Keston Unit, which involved a patient cutting themselves following the breakage of a light bulb. Since then, staff developed robust observation and engagement training. Staff removed potential sharps off the ward, including the replacement of drinking mugs with plastic cups. Staff placed extra care in counting crockery each time it came onto and off the ward during meal times. The support services manager held regular health & safety meetings with senior staff across the hospital.

**Reporting incidents and learning from when things go wrong**

- Most staff knew how to report incidents. Staff were encouraged to approach senior staff where they were unsure about how to complete the incident forms correctly.
- Most staff were not familiar with the term duty of candour, but were able to explain what they would do when mistakes were made.
- We reviewed team meeting minutes from March and November 2015, and incident files between August and November 2015. Staff discussed incidents in multi-disciplinary team meetings and learning from incidents was clearly highlighted.
- Patients involved in incidents were offered an individual debrief, where the reasons for what had happened were discussed and lessons for the future identified. Staff felt supported by the ward manager through debriefs following an incident.

**Duty of candour**

- Staff on Keston Unit were not receiving training on duty of candour and staff we spoke to did not have an understanding of the principles of duty of candour

## Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

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**Assessment of needs and planning of care**

- Keston Unit received referrals from commissioners across the country to assess and treat patients. Staff carried out comprehensive assessments on admission. This included exploring the patient's personal and mental health history, psychiatric and autistic spectrum disorder (ASD) needs, communication needs, and the needs of their family. Family and carers of patients were involved during the initial assessment and admission process. For example, staff met with family members and carers, which gave them an opportunity to share any views or concerns about particular patient's needs.
- The ward doctor was responsible for providing patients with a full physical health examination on admission. Staff informed us that physical checks were carried out weekly. However, out of the five care records we examined, we noted that two care records of weekly physical checks had not been completed fully.
- Some patients received medicines that could have adverse effects on their health. When this was the case, staff completed appropriate checks. Staff also arranged for the required follow-up tests, including regular blood tests for patients receiving the antipsychotic medication clozapine.
- Care planning was taking place and the care plans reviewed involved the views and wishes of patients and were individualised. The evaluation and review of care

plans was taking place regularly. The ward was not using a standardised care planning template but aimed to meet the needs of individuals through specific and adapted care plans based on patient needs and level of risk. However, the care plans reviewed did not demonstrate a holistic approach and lacked detail of social and communication needs of patients and planning of therapeutic activities. Discharge planning was discussed at care programme approach (CPA) meetings.

- The trust used an electronic record system for documenting and accessing confidential clinical notes. This was password protected and staff had individual passwords.

**Best practice in treatment and care**

- Staff used national institute for health and care excellence (NICE) guidelines when they were making treatment decisions. Staff accessed NICE guidelines electronically to obtain guidance and recommendations. Weekly pharmacist visits monitored the quality of medicines management. The Maudsley prescribing guidelines also informed prescribing of medications. The ward doctor presented and discussed patient cases that involved complex therapeutic and diagnostic pathways to consultant colleagues three times a year. The ward doctor attended annual prescribing masterclasses organised by the British Association of Psychopharmacology
- Patients had access to good physical healthcare, including access to specialist services. Keston Unit worked closely with local GPs. At the time of inspection, 7 out of 9 patients were registered with a local GP. GPs were contacted to provide particular health services, for example to administer flu jabs. Patients had access to a dietician from the eating disorders unit. The ward did not provide any physiotherapy services to patients. One patient with mobility issues privately arranged and funded regular weekly physiotherapy. The occupational therapy team and nursing staff supported patients through organised therapeutic walking exercises three days per week. However, not all patients took part in organised activities. Staff informed us that 2-3 patients at most attended any one particular activity organised through occupational therapy.
- The ward used health of the nation outcome scales (HoNOS) to assess and evaluate the effectiveness of interventions. Staff also used the OCD rating scale and Becks Depression Inventory to measure outcomes and progress for people who used the service.
- The ward manager informed us of hospital-wide quality walk-rounds conducted by the senior management team to share good practice. Regular audits on care planning, risk assessment and patient engagement levels with activities were taking place.

**Skilled staff to deliver care**

- Multidisciplinary teams of professionals provided care and treatment. This included full-time staff such as psychiatrists, occupational therapists, nurses and health care assistants. Patients also received input from a social worker twice weekly, a pharmacist once weekly, and dieticians from other wards within the hospital. The ward had access to a speech and language therapist.
- Staff told us that patients had access to a psychologist from the Cedar therapy unit. The ward psychologist position at Keston Unit had been vacant for two months though the hospital was in the process of recruiting a psychologist with ASD specific training. This meant that therapeutic interventions available to patients had been limited.
- Four health care assistants had been recently recruited. New staff received 1-2 weeks of supernumerary induction training supervised by experienced staff when starting work on the ward. Bank staff also had an induction programme to ensure they were familiar with the ward.
- All patients admitted onto the Keston Unit were diagnosed with a form of ASD, and some patients were identified as having learning disabilities. However, staff had not received any specialist training related to managing or working with people with these specific needs. This meant that there was a risk of staff not being adequately prepared to work in this type of clinical setting. This was supported by feedback from some staff, who felt overwhelmed initially working with the complexity of needs the people who used the service.
- A supervision process was in place on the ward. The ward manager supervised qualified staff and the qualified staff supervised health care assistants.
- Staff had completed an appraisal.

**Multi-disciplinary and inter-agency team work**

Good

# Wards for people with learning disabilities or autism

- Regular weekly multi-disciplinary team (MDT) meetings were taking place. Staff discussed and shared any significant events including changes to patient risk level, as well as key changes to medication. The MDT reviewed each patient at least every two weeks.
- Nursing handovers took place twice daily as staff shifts changed. There was effective handover between shifts. Staff were able to explain how they would handover information to colleagues about high-risk patients on close observations. Staff felt confident and prepared for shifts with the information they received during handover. Staff recorded this information on the patient white board in the nursing office, which made information easily accessible for staff coming onto the ward.
- Staff liaised with a wide range of external agencies and commissioners in relation to each patient.

**Adherence to the MHA and the MHA Code of Practice**

- Five out of the nine patients on the ward were detained under the Mental Health Act (MHA). Nursing staff completed mandatory training on the MHA. Copies of the Mental Health Act Code of Practice were not available on the ward.
- Staff had completed assessments of capacity to consent to treatment forms in all five medicines administration record (MAR) we checked.
- However, in one patient care record reviewed showed that the medication specified on the consent to treatment form for a detained patient did not match with the medication that was prescribed on the medicine chart.
- The care records of detained patients showed that they had been informed of their rights under S132 on admission, and during the renewal of a section.
- Detention paperwork was up to date and had been completed correctly. Staff undertook regular MHA compliance audits, including an annual audit.
- An Independent Mental Health Advocate Services (IMHA) were not provided by this service. The care records reviewed showed that patients had not accessed IMHA services. The staff we spoke to were not aware of how to access IMHA services for patients and fed back that patients had to request the IMHA services from their placing authorities.

**Good practice in applying the MCA**

- Nursing staff completed mandatory training on the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS).
- Keston Unit had submitted two patient applications for authorisation of a DoLS in the six months preceding the inspection. Care records showed evidence of assessment of mental capacity. Knowledge of the Mental Capacity Act varied between staff but staff were able to give examples of seeing the ward manager carrying out decision-specific capacity assessments, such as for patients managing their individual finances.

## Are wards for people with learning disabilities or autism caring?

Good

**Kindness, dignity, respect and support**

- We observed interactions between staff and patients at the Keston Unit. We saw kind and caring staff. Staff displayed an understanding of individual patient needs. Staff showed empathy, care and compassion when they spoke about patients. Staff engaged with patients in a supportive and respectful manner. Staff encouraged patients to engage in activities. For example, we observed the occupational therapy assistant visiting each individual patient in the morning to plan daily activities. We observed staff supporting patients with eating during meal times. However, we also observed a lack of staff engagement with patients that were on close observations. The ward doctor showed enthusiasm and passion when he spoke about patients getting better and progressing out of psychiatric care.
- Patients told us that staff listened to their worries and concerns, and spent time getting to know and understand them. Patients felt safe and respected. One patient told us that they felt frustrated by the high levels of close observations, particularly as bedroom doors were required to be kept open. We also spoke to former patients from the ward who spoke very highly of the staff, and felt very supported and involved in their care.
- We spoke with three carers of patients. They told us that staff were very professional, caring and compassionate, and made effort to get to know their patients. One carer also told us that they felt the personal space of patients

was limited with the high levels of observations. The lack of space on the wards meant that patients were limited with the amount of private spaces they could access.

- Nursing staff had an in-depth knowledge of patient's individual backgrounds and individual needs. The ward manager knew about the personal and family background to each patient, his or her progress, their current care plan and day to day risks.
- The occupational therapist was able to explain how tailoring activities towards each patient was important for engagement, for example using a music quiz for a patient who enjoyed particular music.
- Nursing staff explored sexuality, spiritual and religious needs during initial assessments on admission. There was no access to a designated area in the ward or hospital site to meet the spiritual, religious or cultural needs of people from different backgrounds.

**The involvement of people in the care they receive**

- An information pack was given to patients on admission to the ward. This contained information about the ward, activity timetables, and purpose and aims of the ward.
- Patients were able to raise any issues or concerns they had at the weekly patient community meetings. We reviewed community meeting minutes between September 2015 and November 2015. Staff documented patient's requests, for example access to mobile phones and wi-fi. Staff collected feedback from patients both formally through discharge questionnaires, and informally through verbal communication during care planning. Senior hospital staff reviewed feedback returns during the discharge process.
- The MDT involved families in a patient's care and treatment where appropriate. Carers received information brochures about the ward. Carers were able to share their views and concerns with staff during the initial assessment of a patient. Carers attended 6-monthly care review meetings of patients. One carer fed back they had to chase staff to receive information about patients.
- Former patients of the Keston Unit visited the ward to speak with current patients. Former patients were able to offer encouragement and support. Patients spoke very highly about being able to engage with former patients that experienced similar mental health care.
- Patients were not involved in higher-level decisions relating to the service, or the development of the ward. Patients were not involved in the recruitment or training of staff.
- Patients told us that they had input into their care plans and received copies their care plans to read and make suggestions to contribute to care planning.

**Are wards for people with learning disabilities or autism responsive to people's needs?**
(for example, to feedback?)

Good

**Access and discharge**

- Keston Unit received referrals made by commissioners from around the country. At the time of inspection, the ward was running at full occupancy. The average bed occupancy between January 2015 and November 2015 was 100%.
- When patients went on leave for short periods of time they were able to return to their individual bed and it was not used for other purposes
- In the case of urgent medical or emergency care, patients had access to the local Princess Royal University Hospital (PRUH).
- People admitted to the ward had been diagnosed with autistic spectrum disorder (ASD) combined with other complex psychiatric co-morbidities.
- The MDT worked in partnership with commissioners and care co-ordinators to plan discharge from the unit. However feedback received from commissioning bodies prior to inspection raised concerns that the length of stay of patients was too long and the provider was not planning discharges effectively. A recovery based approach to care was not evident in the philosophy of the service or the care records which were reviewed.
- In one care record reviewed, we saw examples of historical notes of failed community placements for a patient who had been on the ward for long periods of time though the care plan did not address this part of their care.

Good

# Wards for people with learning disabilities or autism

**The facilities promote recovery, comfort, dignity and confidentiality**

- There was a communal lounge used for activities, dining, and relaxation. The communal lounge was not big enough for nine patients with complex individual communication needs as the communal area was small and meant that there was limited space for patients to move around. The communal lounge also had a seating area with seats, which were close together and meant that patients had to sit close together with limited personal space.
- A telephone could be accessed for patients to make personal calls.. The community meeting minutes documented that patients made requests for full access to mobile phones.
- Space for patients to use when meeting family and carers was limited. Most patients met their family and carers in their bedrooms. The ward had a small female lounge, which was also used for interviews and as a quiet area. This also meant that there was a risk of compromising the privacy and dignity of patients using the female lounge. Patients did not have access to a relaxation room, or a sensory room. The main clinic room used to examine patients was located on a different ward on Lower Court.
- Staff carried out menu planning with patients every morning. Patients had a wide variety of choice of food with access to vegetarian, gluten-free, and food suitable for lactose-intolerant patients. Family and carers told us the food at Keston Unit was good.
- Patients were able to personalise their rooms, hang personal pictures on the wall and customise the layout of furniture in their rooms. Patients had access to a safe to store valuables and possessions in their bedrooms.
- Therapeutic activities were available to patients throughout the day, including Saturdays. These included arts & crafts, music appreciation, therapeutic walks and gardening club. Engagement with activities was variable and staff told us that some patients did not always engage with activities. We observed occupational therapy staff working and encouraging patients to attend planned activities on the ward. .

**Meeting the needs of all people who use the service**

- One patient on the ward had mobility needs, and used a wheelchair. Staff ensured the patient's bedroom had handrails and bed-rails to mitigate the risk of falls. Staff ensured that alarm systems were adequate for patients requiring disabled access. Staff took into account mobility difficulties of patients when planning activities.
- Information leaflets were not presented in easy to read or pictorial formats to meet the communication needs of people with autistic spectrum disorders . We saw leaflets on safeguarding for visitors and volunteers on display at the hospital reception.
- Staff informed us that the ward had access to religious books and prayer mats. A priest visited the hospital once a week to offer religious services. Staff explored sexuality, spiritual and religious needs during initial assessments on admission. There was no access to a designated area to meet the spiritual or cultural needs of people from different backgrounds.

**Listening to and learning from concerns and complaints**

- There were three complaints raised within the past twelve months. Appropriate investigation and follow up action plans were in place for complaints and the ward responded to complains according to the complaints policy and process. One of these complaints was upheld and none of these complaints were referred to the ombudsman
- Family and carers of patients were able to explain how to make a complaint, what they would do, and knew who to contact, if they had a complaint about Keston Unit. Some carers had raised issues about staff not respecting the private space of patients, which they felt compromised patient dignity. Family and carers of patients felt that staff took their general concerns seriously. Patients had the opportunity to raise any issues they were concerned about at the community meetings.

## Are wards for people with learning disabilities or autism well-led?

Good

**Vision and values**

Good

# Wards for people with learning disabilities or autism

- Staff displayed a good understanding of the aims and purpose of the ward in caring for patients with ASD and complex psychiatric co-morbidities. However, staff were not aware of any structured organisational vision or values.

**Good governance**

- Staff had regular team meetings and the ward manager had good oversight on key ward targets. This included mandatory training, staff appraisal and supervision, recruitment and staffing, and external inspections. The ward manager had access to a range of information about staffing levels and staff training, and annual audit information.
- The ward manager met weekly with the ward consultant and felt supported by senior managers. The ward manager had sufficient authority to make improvements to the way Keston Unit operated. The ward manager was highly valued by the staff team. The ward manager ensured the ward was adequately resourced.

**Leadership, morale and staff engagement**

- Staff told us they enjoyed working at the Keston Unit. Staff morale was high across all disciplines. Staff were positive about their immediate management and ward management support. Staff had a good understanding of the senior management team. Staff felt listened to by senior managers if they ever had an issue. Staff received appropriate support from their colleagues and managers, which helped to ensure they were able to work effectively.
- Staff were able to suggest improvements and these were incorporated into an action plan. All staff told us they felt able to raise any concerns about patient care.
- Some staff had opportunities to become mentors after completing a three month mentorship course at King's College Hospital. This meant that healthcare students that were on placements on the ward could receive appropriate supervision and mentoring by staff whilst on training.
- Staff did not have any concerns around bullying or harassment.

**Commitment to quality improvement and innovation**

- Keston Unit accepted admission of patients with very complex needs. Staff told us that some of their biggest successes were caring for patients with complex health and social care needs and then seeing improvements in their wellbeing.
- Staff informed us of about hospital-wide quality walk-rounds as a form of learning and sharing in good practice. The ward doctor presented and discussed patient cases to consultant colleagues three times per year.

Requires improvement

# Specialist eating disorder services

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

## Are specialist eating disorder services safe?

Requires improvement

### Safe and clean environment

- The wards were both clean and, though small, were comfortably furnished. The bedrooms were all ensuite and the kitchen and lounge areas were tidy.
- Both the acute and progressive and transition wards had clear lines of site along the main ward corridor although there was limited visibility if staff were in the office.
- Staff had carried out ward specific ligature risk audits in January 2015. These identified ligature risks and outlined management plans to minimise risk. Ligature cutters were available on both wards.
- Both wards were mixed sex and all bedrooms were located on one corridor. At the time of our inspection, there was one male patient on each ward. Although all bedrooms had ensuite bathroom facilities, there was no system that staff were able to identify to cluster patients during times when the wards had more than one male. The wards did have dedicated female lounges though there was a high level of monitoring and observation of patients and patient dignity and privacy was maintained.
- Both wards had small and slightly cramped clinic rooms. There were no controlled drugs stored on either ward. These were stored in the Lower Court ward. On the progression and transition ward, the clinic room did not contain a bed. The emergency equipment was shared between the wards and was placed in the acute ward nursing office. Staff checked this regularly and progression ward staff could access it within three minutes.
- Neither ward had a seclusion room. Physical restraint was sometimes necessary, mainly for the insertion of nasogastric tubes but this happened in patient's bedrooms and was recorded appropriately. Where patients were restrained to enable feeding to take place, capacity to consent to treatment had been assessed and recorded appropriately and this intervention was clearly outlined and documented in patient's care plans.
- Both wards were carpeted throughout which may have compromised infection control standards. The ward areas in the eating disorders unit were carpeted to create a welcoming, homely environment for people who may be receiving care as an inpatient for a long period of time. The Department of Health guidance relating to infection control in hospitals indicates that carpeting should not be used in clinical areas. To mitigate risks of transmission of infection, the carpets in the unit were cleaned regularly and there was a comprehensive cleaning schedule. The clinical room where medicines were administered and examinations carried out was not carpeted.
- Hand washing facilities were available in the ward areas and alcohol gel was accessible at the entrance to the wards.
- Staff on the both wards were issued with personal alarms that were checked regularly. There were wall alarms in communal areas and bedrooms which triggered the alarm system when used.

### Safe staffing

Requires improvement

# Specialist eating disorder services

- The acute ward had two nursing vacancies and the progression ward had none. The staff establishment for both wards was two qualified and two unqualified staff during the day and one qualified and two unqualified staff at night.
- Actual staffing levels were usually significantly higher. Where individual patients needed higher levels of support extra staff were easy to access through the hospital bank and the ward managers could do this without further authorisation. Bank staff were familiar with the wards. There was rarely any need to use agency staff.
- Staff and patients said there were sufficient numbers of staff for one to one sessions, carrying out activities and facilitating leave.
- There was consultant cover on the ward each day and there was a ward doctor for each of the wards. The hospital provided its own internal on call rota system so that doctors were always available.
- On the progression and transition ward, 74% of staff had completed mandatory training.

**Assessing and managing risk to patients and staff**

- Risk was assessed immediately for new admissions. Risk was clearly reassessed and incorporated in the care plans and the multi-disciplinary ward round notes contained in the records. During the ward round the risks for each patient were reviewed.
- All the care records we looked at had risk-screening forms, which were regularly updated. The aim of these forms was to identify the appropriate observation level for each patient.
- Details of how observation levels were decided for each patient and the need to search personal possessions to keep patients safe were explained clearly in the handbook that was given to all patients on admission.
- Nursing staff were trained in the prevention and management of violence and aggression. This meant they could de-escalate potentially challenging incidents and safely restrain patients if needed.
- Safeguarding was part of mandatory training and staff showed a good understanding of safeguarding issues.
- In the acute ward clinic room the signing sheets for checking stock medication had run out and checks were recorded on blank pieces of paper.

**Track record on safety**

- There were four serious incidents recorded for the eating disorders service between March and September 2015, relating to restraint and the disclosure of alleged abuse.

**Reporting incidents and learning from when things go wrong**

- Staff reported all incidents on paper records, which were then transferred to the electronic system by the ward clerk. The senior management team meeting for the eating disorders service reviewed all the incidents.
- We reviewed five incident reports that related to restraint on the wards. All the reports correlated with the notes on the electronic care records and appropriate physical health observations and checks were recorded in each case.
- The incident forms had a lessons learnt section, which was completed after the incident, which were being discussed in the senior management meeting. The ward managers said that incidents were discussed in every handover and multi-disciplinary team meeting.
- On the acute ward, the record of the staff meeting in September 2015 said that staff wanted to increase the level of debriefs taking place after incidents of restraint. At the time of the inspection staff we spoke with reported that debriefs were now happening.

**Duty of candour**

- Feedback from patients on the progression and transition ward indicated that staff came to speak to patients on the ward following an incident to offer debrief.
- Staff were not receiving training on the Duty of Candour. However we found that the hospital promoted a culture of openness and transparency. Staff on the ward felt able to raise concerns and issues relating to patient care.

## Are specialist eating disorder services effective?

(for example, treatment is effective)

Requires improvement

**Assessment of needs and planning of care**

Requires improvement

# Specialist eating disorder services

- The standardised admission process included an assessment of each patient's physical and mental health. An assessment of each patient's needs took place immediately after admission. The dietitian was involved in the assessment and prepared a personalised meal plan based on the patients' current nutritional state.
- Where a patient was very unwell, the ward used a modified early warning score tool. Staff used this tool to measure vital signs for physically unwell patients with an eating disorder. Staff from the hospital had developed this tool and had been recognised for its innovation.
- Physical health care plans were in place for all patients on both wards. The service received regular visits from a senior physician at the local general hospital.
- The twelve care records all contained detailed care plans across a range of needs with a focus on weight gain recovery.
- Staff used the care notes electronic system, but there were also paper files for each patient.

**Best practice in treatment and care**

- Each ward had a dining room and separate lounge area. The dining room was reserved for dining only during allocated mealtimes, as recommended by the Royal College of Psychiatrists' standards for adult inpatient eating disorder services.
- The dietician outlined that people with severe and enduring eating disorder were offered different support to those not suffering from a less severe eating disorders. The plans for weight gain were in line with NICE guidelines. NICE guidelines suggest weight gain should be around 0.5-1kg a week in inpatient settings.
- Although patients were able to access the therapies offered by practitioners in the Cedar Unit, a dedicated psychologist was not currently part of the multi-disciplinary team for the acute or progression and transition wards. An eating disorder examination questionnaire was used to assess and record severity and outcomes for patients using the service. At the time of the inspection an analysis of the results was not available as the psychologist completing this work was no longer in post. This was an important way of measuring outcomes for patient.
- An audit of risk assessments, patient observations & engagement and care plans were conducted on both wards in October 2015 and showed that risk assessments did not have corresponding management plans that addressed that identified risks on the acute ward. Moreover, the audit showed that patients were not involved in risk assessments on both the acute ward and the progression and transition ward. There were no action plans or follow up measures in place to address the outcomes of these audits on either of the wards.

**Skilled staff to deliver care**

- There was a dietician who worked 28 hours a week across the two wards. This was in line with the Royal College of Psychiatrists' standards for adult inpatient eating disorder services, which state each ward should have dedicated input from a dietitian. Staff felt the input from the dietician was very good. There was a social worker who provided six hours a week input to the team. There was occupational therapy (OT) input to the team. The hospital had two full time OTs and five OT assistants. The eating disorders service shared one of the OTs with the Lower Court ward.
- Domestic staff were integrated on the ward and felt very positive about their role. They received an induction to the service and breakaway training. The domestic staff felt there was positive interaction between themselves and patients on the ward, as well as between themselves and ward staff.
- There was no record of individual clinical supervision taking place for staff on either of the wards. Some staff we spoke to had not received individual clinical supervision at any point, others had received it once or twice over the period of one year. There was a fortnightly group clinical supervision meeting available to all staff which was facilitated by someone external to the ward teams. Records of attendance from the fortnightly group supervision from March to October 2015 showed that of 26 staff, 19 attended the group supervision once, four attended twice, two attended three times and one attended four times.
- The hospital reported that 96% of staff had received appraisals within the past year and ward managers said that all staff had been appraised.
- There were regular staff team meetings.
- Nursing staff had received mandatory training at induction but had not received specialist training in working with people with eating disorders. The hospital had not employed nursing staff with speciality expertise

of working with people eating disorders. A lead consultant had specialist expertise in working with people with eating disorders, though this was not reflected in the wider multi-disciplinary team. Patients reported that the understanding of eating disorders varied across the staff members. Patients reported that at meal times, the level of skilled support provided by staff varied between different staff.
- The ward mangers said that they had not had to implement polices to address poor staff performance.

**Multi-disciplinary and inter-agency team work**

- There were two multi-disciplinary ward round meetings each week, one for each consultant. In addition, there was a consultant led community meeting every Friday.
- There was a morning meeting every day for all ward managers and the clinical services manager.
- There were morning and evening handover meetings for nursing staff every day. During these meetings patient progress, risk and care plans were discussed.
- Staff on the progression and transition ward felt there were good links with community services although the level of communication and planning varied depending on which area the patient had come from.

**Adherence to the MHA and the MHA Code of Practice**

- The patients we spoke with had a good understanding of their rights under the MHA. Patients had their rights explained to them when they were initially detained or when their section was renewed. There was an approved mental health professional report in each of patient records where they had been detained.
- Staff told us that a patient had to request to see an independent mental health advocate (IMHA) and then the patient's local authority would fund the IMHA service. The hospital provided a general advocacy service. We spoke with the advocate who informed us that although they are IMHA trained they do not provide IMHA services for the hospital.
- On the acute ward there were nine patients at the time of our visit. Two were subject to section two of the MHA and four were subject to section three of the MHA with two informal patients. On the progression ward there were eleven patients at the time of our visit. Four were subject to section three of MHA and seven were informal.
- Staff said they felt confident in the use of the MHA and said that there was a very effective MHA administrator at the hospital. The care records we looked at for detained patients all had the section papers and consent to treatment forms scanned and uploaded to care notes.
- For one patient the Responsible Clinician had documented in their capacity assessment for urgent treatment that the patient lacked the capacity to consent to their medicines for mental disorder. Medicines were administered under the authority of Section 62 of the MHA until a second opinion appointed doctor (SOAD) visited. However, one psychotropic medication that was prescribed to the patient was not accounted for on the form. This medication was not given under an appropriate legal authority. Outcomes of capacity assessments were not recorded accurately or clearly on the consent to treatment form.

**Good practice in applying the MCA**

- The ward mangers both said they felt their staff were confident in the application of the Mental Capacity Act, which was covered in mandatory training.
- Capacity issues were given significant consideration in care plans, patient reviews and multi-disciplinary team meetings.
- Thinking about capacity did extend beyond consent to treatment issues for eating, on both wards.

## Are specialist eating disorder services caring?

Good

**Kindness, dignity, respect and support**

- Staff demonstrated a good level of knowledge about individual patients' care needs.
- During the ward round, we observed staff showing considerable skill in de-escalating a situation with a patient who was angry and in comforting another patient who was very upset.
- Patients said they felt safe on both wards.
- Patients reported that most staff were kind and helpful.
- Patients said that staff respected the level of information they wished to share with their families and/or carers.

Requires improvement

# Specialist eating disorder services

- Patients said there should be more input and interaction from staff during post meal support.
- We received feedback from the advocacy service that some patent complained that staff had not treated patients with respect and were sometimes dismissive though we did not observe this during the inspection,

**The involvement of people in the care they receive**

- Patients and staff knew how to access the advocacy service and the advocate attended the ward regularly and came to ward rounds when invited.
- Four of the five records we looked at on the progression wards indicated that family therapy was taking place and all the care records we looked at documented contact from nurses and consultant psychiatrists with patients' families.
- Patients on the acute ward said the suggestion box was quite a good way to give feedback about the service.
- The two wards have a joint community meeting on Friday mornings each week, which the consultants and nursing staff also attended.

## Are specialist eating disorder services responsive to people's needs?

(for example, to feedback?)

Good

**Access and discharge**

- The eating disorders unit had a national catchment area and various commissioning bodies funded places. There were specifically developed relationships for referrals from Sussex and Kent. Information was collated from the referrer and a waiting list was kept. All admissions to the unit were planned.
- The ward would send staff to assess patients who were in general hospitals and the unit had taken some patients who were very physically unwell.
- The multi-disciplinary team decided whether to accept referrals. The unit aimed to give referrers a definitive decision within a week.
- Most patients on the progression ward had been admitted in 2014 and those on the acute ward in 2015, however there was one patient who had been on the unit for 16 years. This was a very complex case including ongoing safeguarding and Court of Protection issues and although attempts had been made to discharge this person it was decided by the agencies involved in this person's care that the unit provided the only safe environment currently able to keep this patient alive.
- Care plans showed no evidence of discharge planning which was in particular pertinent for two patients who had been on the acute ward for nine months and four months respectively. (On EDU progression and transition there was evidence that discharge planning was discussed at care programme approach (CPA) meetings. However, it was difficult to gain an understanding of what the overall plan was. Identified risks had a corresponding care plan but it was not always easy to match the identified risk to the corresponding care plan.

**The facilities promote recovery, comfort, dignity and confidentiality**

- There were no therapy rooms available on the wards. Patients' attended the hospital's therapy centre for therapy sessions. This made it difficult for patients under observation or for those who were too physically ill to access therapy.
- There were no activity rooms on the wards. There was an occupational therapy room on the hospital site, but it was located off the ward.
- One to one sessions with nurses and patients took place in the patient's bedroom due to limited rooms on the wards.
- There were no visiting rooms located on either of the wards. Patients saw visitors in their bedrooms or off the ward in an open lounge area on the hospital site or in the hospital garden.
- Patients had access to their phones apart from at meal times when this was discouraged.
- Informal patients were able to access the garden freely and could come and go from the ward as required. Patients who were detained and had leave could access the hospital garden.
- Patients and staff reported that there was no problem with the quality of the food. The dietician also noted that there was a reasonable choice of food available. The food was cooked on site.

Requires improvement

# Specialist eating disorder services

- Patients on both wards had access to hot and cold drinks at all times. This would also be risk assessed on an individual basis if necessary.
- Patients were able to personalise their bedrooms and this was evident on both wards.
- All the bedrooms had safes where patients could secure their valuable possessions.
- Patients and staff reported that there were a good number of activities that took place on each ward. These included a mindfulness group, nutrition group, yoga, arts and craft group and walking group. The transition and progression ward had groups promoting independence with food preparation and meals.

**Meeting the needs of all people who use the service**

- Disabled access was provided with a room, which was accessed by both wards and was situated in between each ward. One set of doors in the corridor could be closed off so that the bedroom and bathroom was either on the acute ward or the transition and progression ward.
- There was lift access to the acute ward for those requiring it due to disability or acuity of illness. Access to the progression and transition ward from the lift was through the acute ward.
- The eating disorder service patient handbook contained information about available therapies and about the complaints procedure.
- The service was able to access interpreters where necessary.
- There was a list issued to patients about places of worship and religious services in the area.

**Listening to and learning from concerns and complaints**

- There were three complaints made in the eating disorders service in the past twelve months. All of the complaints related to patient experience of poor attitude of staff. All of these complaints resulted in appropriate follow up with human resources department and implementation of training follow up for staff if required. None of these complaints were referred to the ombudsman
- Complaints were promptly resolved on both wards. The ward managers said that most of the complaints received were about food and diet. The ward manager initially reviewed and, if possible, responded to complaints. If the complaint was serious or it was not appropriate for the ward manager to respond, the clinical service manager would allocate an independent staff member to investigate the complaint.

## Are specialist eating disorder services well-led?

Good

**Vision and values**

- Staff said that they found the Priory to be a good employer and they were supported to do their job.
- Staff said that the eating disorder services had a clear goal of re-feeding, weight gain and mental health recovery.
- Staff said that senior managers in the hospital were visible and approachable.

**Good governance**

- The wards had strong leadership in the two consultant psychiatrists and the service had a considerable national reputation, partly because of the development of the modified early warning scores for people with an eating disorder.

**Leadership, morale and staff engagement**

- All the staff we spoke with were very positive about their jobs.
- Staff said they felt proud of the consultants on the team.
- Staff said both wards had a happy workforce.

**Commitment to quality improvement and innovation**

- A new occupational therapy (OT) post and new OT assistant posts were created within the last year for the service.

# Outstanding practice and areas for improvement

## Outstanding practice

- The eating disorders service had developed a tool to monitor when a patient's physical health was deteriorating which was being adopted nationally. This was an early warning score system which was adapted by clinicians at the hospital and was being used as a tool to monitor the physical health of patients receiving treatment. This had been developed and evaluated by staff in the service who had evaluated its effectiveness through research studies.

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure training is provided so that staff are able to effectively support patients with substance misuse issues, eating disorders and autistic spectrum disorders.
- The provider must ensure on the acute ward that risk assessments are comprehensive and include clear detailed management plans and service user involvement
- The provider must ensure that staff receive regular supervision in the eating disorders services.
- The provider must ensure that the movement of stock medication is recorded so there is an audit trail for medication in the hospital.
- The provider must ensure that allegations of historical sexual or physical abuse are appropriately referred to the local authority, and that an audit system is introduced which effectively monitors safeguarding alerts.

### Action the provider SHOULD take to improve

- Care planning on the acute ward should actively involve patients and their views should be reflected in the care planning documentation.
- The provider should ensure that staff understand the practice of assessing a patients capacity to consent to treatment especially on the acute ward and that this is recorded in their records.
- The provider should work with the placing commissioners to ensure patients who are detained under the MHA can access an independent mental health advocate where needed.
- The acute ward and ward for people with autistic spectrum disorders should ensure that accurate records are kept of patient's physical health checks.
- The ward for people with autistic spectrum disorder should ensure the care plans reflect people's social and communication needs.
- The acute ward and eating disorder service should ensure that where audits are completed that action plans are in place and the learning is followed up.
- The eating disorder service should have access to a psychologist who can collate and monitor the outcome measures being used in the service.
- The provider should ensure there is space for patients on the eating disorder wards to access therapy on the ward if needed.
- The provider should ensure that on the ward for people with autistic spectrum disorders that restraint is recognised and recorded as an incident.
- The provider should ensure that on the ward for people with autistic spectrum disorders that a copy of the MHA Code of Practice is available.
- The provider should ensure that on the ward for people with autistic spectrum disorders that restraint is recognised and recorded as an incident.
- The provider should ensure that on the ward for people with autistic spectrum disorders that staff ensure they interact positively with individual patients when they are observing them closely.

# Outstanding practice and areas for improvement

- The provider should ensure that on the ward for people with autistic spectrum disorders that opportunities for patient involvement are developed further such as patients helping with staff interviews.
- The provider should ensure that on the ward for people with autistic spectrum disorders that planning for discharge forms a central part of the patients care planning process
- The provider should ensure that on the ward for people with autistic spectrum disorders that careful consideration is given to the use of the physical environment to ensure there is enough communal space and privacy for female patients.
- The provider should consider if it is possible to provide a multi-faith room to meet peoples religious and spiritual needs.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require treatment for substance misuse<br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>The provider had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff being deployed and that they had the appropriate supervision and support to enable them to carry out their duties they are employed to perform.<br>In the eating disorder service staff had not received regular clinical supervision.<br>Staff were not provided with the training they needed to support patients with a range of complex needs including substance misuse, eating disorders and autistic spectrum disorders.<br>This was a breach of regulation 18(1)(2)(a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require treatment for substance misuse<br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>The provider had not ensured that care and treatment was provided in a safe way for patients.<br>The risk assessments on the acute ward had not been completed in a comprehensive manner, which meant there was a potential of patients individual risks not being managed robustly.<br>The records of stock medication in the hospital were not being maintained as the medication was moved between wards. This meant there was not a clear audit trail for this medication.<br>This was a breach of Regulation 12 (1)(2)(a)(b)(d) |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require treatment for substance misuse<br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br>The provider had not ensured that service users were protected from improper abuse and treatment. The provider had not ensured that systems and processes were in place to operate effectively and to investigate, immediately upon becoming aware of any allegation of, evidence or allegation of abuse.<br>On Lower Court, allegations of historical sexual or physical abuse were not being referred to the local authority as a safeguarding concern.<br>The safeguarding audit was not robust and safeguarding concerns which were disclosed or identified at a hospital level, and any subsequent referrals to a local authority, were not being properly monitored.<br>This was a breach of Regulation 13 (1) (2) (3 |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require treatment for substance misuse<br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br>The provider had not ensured that service users were treated with dignity and respect. They had not ensured the privacy of the service users.<br>On the acute wards and eating disorder wards the provider had not created clear zones for male and female patients to provide as much separation as possible.<br>This was a breach of regulation 10(1)(2) |