The Priory Hospital Roehampton

Quality Report

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Date of inspection visit: 9, 10 & 21 November 2017
Date of publication: 26/02/2018

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?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
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 this service as **requires improvement**. This was based on the aggregated ratings from our inspections of the acute, eating disorder and children's and young people's services. We also inspected the substance misuse services, but do not yet rate these services. There were a number of significant concerns, particularly about the acute wards and substance misuse service provided at the hospital.

We found the following areas needed improvement:

- The current layout of the three acute wards presented potential risks to the safety of the patients admitted to these wards. The risks to patient safety were greatest on East Wing, on which the layout over four floors made it hard for staff to observe the multitude of risk areas, but were also present on West Wing and Garden Wing including in the garden areas. The potential risks were a result of poor lines of sight and the presence of multiple ligature points. The hospital was working to mitigate these risks through consultants reviewing the appropriateness of admissions before they were agreed, ensuring prompt assessments at the time of the admission, observing patients based on their individual needs, providing bedrooms with enhanced safety features, restricting access to parts of the wards and the use of technology through specially designed camera surveillance to monitor patient movement. They had also provided training for staff on relational security. Despite all these mitigations, the current physical environment of the building was not suitable for adults with acute mental health needs. The hospital had recognised this and had stated its intention to relocate the service on East Wing and completely redevelop the West Wing and Garden Wing environments. The work was due to be completed by mid-November 2018. East Wing service needed to be relocated as a matter of urgency and the provider needed to review if they could continue to provide a safe service on West Wing and Garden Wing until the redevelopment work had been completed.
- At the previous inspection in August 2017, we identified concerns about the safety on Garden Wing, largely as a result of patients, visitors and staff passing through this ward to reach other parts of the hospital. At this inspection, steps had been taken to improve the safety of the ward such as two additional staff worked during the day to monitor access to the ward and to observe and engage with patients in the corridor leading to the garden area. Despite these measures, staff who were not working on the ward continued to walk through Garden Wing to access other areas of the hospital. This compromised the privacy and dignity of patients on the ward.
- Staff changes and the high use of agency staff who were unfamiliar with the wards continued to be an issue and impacted on the consistency of care. Patients told us that they did not like it when agency staff were on shift as they were unfamiliar to their needs. There was a high turnover of staff on Garden Wing, which impacted on the morale on the remaining staff. However, the hospital had recently introduced 3-month block booking of agency staff to assist with improving the consistency of care.
- Staff did not always manage medicines safely. Staff did not always record a clear rationale as to why staff administered a certain dose of PRN (as and when) medication.
- In August 2017, we found the dining room on Upper Court was too small and did not provide a positive therapeutic environment for patients with an eating disorder and that some patients were eating in a restaurant area next to the Garden Wing. At this inspection, the work was still not complete and was agreed to be completed by the end of August 2018.
- In August 2017, we found that work was on-going on the self-soothe room on Priory Court and there was no suitable environment for the physical examination of patients on Garden Wing other than

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patients' bedrooms. Since the inspection, the provider had proposed environmental work on the self-soothe room on Priory Court to be completed by December 2017 and had proposed environmental plans to provide an examination room on Garden Wing by 31 August 2018. Until this work was complete, there was still an on-going impact on the privacy and dignity of patients.

At this inspection, we also inspected the substance misuse services. We do not currently rate substance misuse services. We wrote to the provider expressing our concerns about the safety of the patients undergoing medically assisted withdrawal and they voluntarily agreed to suspend admissions until these concerns were addressed as follows:

- The provider did not ensure staff had the necessary skills and followed safe policies and procedures when supporting patients undergoing medically assisted withdrawal.
- Staff did not always assess patients fully prior to undertaking medically assisted withdrawals. They did not always ensure that they explored all areas of risk that could be affected by the detoxification programme or complete brief cognitive assessments. This meant that patients may be at risk of not receiving appropriate support.
- Staff did not always ensure that they sufficiently recorded the decision making process for the administration of medicine to a patient. The lack of recording of the decision-making process meant that the patient could be at risk of not receiving the correct medication in order to stop the progression of alcohol withdrawal symptoms.
- Nursing staff supporting patients with substance misuse had not received specialist training. Some staff did not have a good understanding of the tools used to monitor patients. Following our inspection, the provider implemented a new nursing competency checklist.
- The provider did not robustly monitor the quality of the service provided in the substance misuse services. The governance processes had not identified the areas of concern to provide assurance.
- However, since the August 2017 inspection, we found the following areas of improvement:
- The hospital now had a system in place to monitor how long patients waited to be assessed following admission.
- Staff now completed physical health assessments and monitored vital signs for all patients following rapid tranquilisation. However, there was room for improvement in the quality of recording to evidence that staff attempted to monitor patients' vital signs on more than one occasion if they refused.
- On the eating disorder wards, staff accurately recorded patients' physical health observations as prescribed and escalated any concerns identified. The nasogastric feeding rooms on Priory Court and Upper Court provided safe and clean environments.
- Items in the emergency bags were in date on Priory, Upper Court and Garden Wing.
- The provider had provided physical health training to staff to ensure they understood how to calibrate the blood glucose monitoring machines. Staff now calibrated these machines correctly.
- Staff consulted with patients to improve the interior design in the nasogastric feeding rooms and work was due to be completed by December 2017.
- Permanent staff did not share their computer log-in details with agency staff. They could access the patient records as needed. Staff on all wards knew what to do in the event of a computer outage.
- Following a previous serious incident at the hospital, the provider stated that admissions to Garden Wing and West Wing should not take place out of hours as there was reduced access to regular skilled staff, including medical staff compared to usual working hours. They had identified this as a risk to patients and outlined it in their action plan. At this inspection, out of hours admissions were still taking place. This was due to some patients turning up later than the agreed admission time. There were measures in place to ensure these admissions took place safely.

We found these areas of good practice:

- All patients had current risk assessments, and those we checked were detailed and clear. Staff had

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undertaken training in relational security, and found this helpful in working on the wards. Extra staffing on all of the acute wards enabled more observations and interactions with patients, so that patients felt better supported.

- Care plans were holistic, personalised and demonstrated patient involvement. There was evidence of good physical health care management.
- Staff demonstrated effective relationships with other services and organisations. The safeguarding lead had good working relationships with the local authority. Lower Court was part of the new models of care pilot, in partnership with two London NHS trusts to improve the CAMHS care pathway.
- The hospital sought to improve and keep up with best practice. Wards were providing treatment in line with NICE guidance. The CAMHS and eating disorder ward were part of national recognised accreditation schemes to learn and share practice.
- There was excellent involvement of young people on Lower Court. Patients sat on CAMHS staff interview panels and were involved in the development of their therapeutic programme. Staff were responsive to patient feedback. For example, staff provided young people with Bluetooth cordless headsets, as normal headphones with cords were not allowed.
- Patients spoke positively about staff interactions with them, and we observed staff engaging with patients discreetly and respectfully. Patients said the food was good quality. Patients particularly appreciated the hospital gym and were satisfied with the hospital accommodation.
- The hospital had strong and responsive leadership. Senior management were visible on the wards and consulted with staff regarding changes to services. Senior management had good oversight of the wards and had systems in place to track staff supervision, incidents, safeguarding and complaints for each ward.

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Requires improvement

The Priory Hospital Roehampton

Services we looked at:
Acute wards for adults of working age and psychiatric intensive care units; Child and adolescent mental health wards; Specialist eating disorders services; Substance misuse/detoxification

Summary of this inspection

Background to The Priory Hospital Roehampton

The Priory Hospital Roehampton is an independent hospital that provides support and treatment for people with mental health needs, eating disorders, and drug and alcohol addictions. It has 96 inpatient beds. The hospital provides care and treatment for adults and children experiencing acute episodes of mental illness, an in-patient detoxification and addiction therapy programme, and in-patient care and treatment for adults and children with eating disorders. Services are provided on the following wards:

• Lower Court is a mixed ward and provides care and treatment for 12 children and adolescents up to18 years old experiencing an acute episode of mental illness.

• Upper Court provides an eating disorder services for up to 16 adult female patients.

• Priory Court is a mixed eating disorders service for up to 18 children and adolescents.

• East Wing provides care and treatment for up to 12 adult female NHS patients.

• Garden Wing is a mixed adult ward for people experiencing acute mental illness. It provides services for up to 18 patients.

• West Wing is a private mixed acute psychiatric admission ward and a ward for people participating in the addictions therapy programme. It provides beds for up to 21 patients.

The provider is registered to provide care for the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Treatment of disease, disorder or injury

The service had a registered manager employed at the hospital.

Our inspection team

The team that inspected the service comprised nine CQC inspectors, two inspection managers, a Mental Health Act reviewer, a pharmacist, four specialist advisors with professional backgrounds in nursing and medicine, and an expert by experience. 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. In addition, during this inspection we checked the progress the provider had made in addressing the breaches of regulations identified at the previous inspection in August 2017.

At the last inspection in August 2017, we found breaches of the following regulations:

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 10 (dignity and respect)

Regulation 12 (safe care and treatment

Regulation 15 (premises and equipment

Regulation 17 (good governance)

At the last inspection, we undertook enforcement action against the hospital and served a warning notice (Section 29 of the Health and Social Care Act 2008). We found that the provider had failed to take sufficient steps to address breaches of regulations identified at the previous inspection in October 2016. The provider had failed to ensure that there was a system in place to monitor the time new patients waited for a full initial admission assessment on the acute wards. The provider had failed

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to ensure staff completed physical health assessments and monitored vital signs for all patients following rapid tranquilisation. We also found that Garden Wing did not provide a safe environment for patients.

At the last inspection, we told the provider that it must take the following actions to improve acute wards for adults of working age and specialist eating disorder services.

- The provider must ensure staff complete physical health assessments and monitor vital signs for all patients following rapid tranquilisation. The provider must ensure there are robust systems in place to monitor this.
- The provider must take sufficient steps to ensure that there is a system in place to monitor the time new patients wait before staff complete a full initial assessment on admission to the acute wards.
- The provider must take sufficient steps to ensure there is a safe environment for patients on Garden Wing.
- The provider must ensure staff accurately record patients' physical health observations and escalate physical health deterioration appropriately on Priory Court and Upper Court.
- The provider must ensure that the layout of the ward does not impact on the dignity of patients who are being restrained on Priory Court.
- The provider must ensure that emergency medicines and equipment are checked regularly on Priory Court, Upper Court and Garden Wing, to ensure safe treatment of patients.
- The provider must ensure that relevant staff complete the necessary training to ensure competency in calibration of blood glucose monitoring machines.
- The provider must ensure that the nasogastric feeding rooms on Priory Court and Upper Court are clean, and that cleaning records are up to date to demonstrate that the rooms are cleaned regularly. On Upper Court, the provider must ensure that nasogastric feeds and equipment are stored safely, and there is adequate preparation space for staff to prepare nasogastric feeds.

During the November 2017 comprehensive inspection, the inspection team followed up these areas to see if the provider had made improvements.

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.

During the inspection visit, the inspection team:

- visited all six wards of the hospital and looked at the quality of the environment and observed how staff were caring for patients
- spoke with 28 patients who were using the service
- spoke with the ward managers or acting ward managers on all six wards
- Interviewed staff on the senior management team including the hospital director, director of clinical services, associate director of clinical services, medical director and lead for quality and assurance
- spoke with 32 other staff members; including consultant psychiatrist, occupational therapist, family therapist, psychologist, health care assistants, dietician, nurses, safeguarding lead and therapies manager
- reviewed 15 patient comment cards
- reviewed 33 patient electronic care records
- attended and observed one multi-disciplinary meeting on one of the eating disorder wards
- observed one lunch time meal on one of the eating disorder wards

Summary of this inspection

- carried out a specific check of the medication management on the wards
- attended a community meeting for patients on one of the acute wards
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

We spoke with 28 patients. Most patients said staff were kind, respectful and supportive. Patients on Lower Court said staff were fun and friendly. Five out of the six patients we spoke to on Upper Court said staff were easy to get along with and that staff went out of their way to support them and promote their interests. However, three out of the five patients we spoke to on Priory Court said that staff did not always understand their needs.

Patients said they did not like it when agency staff were on the ward, as they were unfamiliar with their needs. However, most patients said there were enough staff on the ward so that leave or activities were not cancelled.

Most patients said they felt involved in their care and treatment and attended regular community meetings and wards rounds.

On the substance misuse section of West Wing, whilst patients were positive about staff and described them as being compassionate, patients had a mixed view about the how the therapy programme was run. Some patients told us that they were unhappy that therapies did not always start on time and therapists would allow people who arrived late to join in the group. Patients reported that the disruption impacted on their focus in the group.

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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:

Since the last comprehensive inspection, we found the follow areas needed for improvement:

- The current layout of the three acute wards presented potential risks to the safety of the patients admitted to these wards. The risks to patient safety were greatest on East Wing, where the layout over four floors made it hard for staff to observe the multitude of risk areas, but were also present on West Wing and Garden Wing including in the garden areas. The potential risks were a result of poor lines of sight and the presence of multiple ligature points. The hospital was working to mitigate these risks through consultants reviewing the appropriateness of admissions before they were agreed, ensuring prompt assessments at the time of the admission, observing patients based on their individual needs, providing bedrooms with enhanced safety features, restricting access to parts of the wards and the use of technology through specially designed camera surveillance to monitor patient movement. They had also provided training for staff on relational security. Despite all these mitigations the current environments were not suitable for adults with acute mental health needs. The hospital had recognised this and had stated its intention to relocate the service on East Wing and completely redevelop the West Wing and Garden Wing environments. Clear timescales were not yet in place for this work. The East Wing service needed to be relocated as a matter of urgency and the provider needed to review if they could continue to provide a safe service on West Wing and Garden Wing until the redevelopment work had been completed.
- At the October 2016 and August 2017 inspections, we found there were gaps in physical health assessments, and monitoring of patients' vital signs following rapid tranquilisation. At the November 2017 inspection, we found improvements had been made. On Lower Court, staff completed appropriate physical health checks for all 19 incidents of rapid tranquilisation. The hospital had put in place a rapid tranquilisation tracker to ensure that all staff completed physical health assessments and monitored vital signs for all

patients following rapid tranquilisation. However, staff still needed to improve recording to demonstrate they attempted to monitor patients' vital signs on more than one occasion if a patient initially refused this input.

- On Lower Court, not all areas were clean or well-maintained. Patients fed back concerns around the cleanliness of the kitchen at the weekend. We observed some of the surface areas in the kitchen were dusty and had food debris on them. Cleaning records did not include all areas of the kitchen.
- There was insufficient information available to staff administering PRN (as and when) medicines regarding the dose to be administered and they did not have a format for recording how the dose was determined depending on the patient's need, to ensure that the dose administered was not too high. Medicines given to patients on Garden Wing for home leave were not always recorded on medicines administration records. On Lower Court, not all liquid medicines had their opening date recorded.
- Garden Wing had a high turnover of staff. Fifty percent of staff had left in 2017. Patients on the eating disorder wards reported concerns regarding the high use of agency staff, many of whom were unfamiliar with the wards and eating disorders. However, the provider had taken steps to mitigate this by introducing 3-month block booking of agency staff.
- There was no system in place to check on mandatory training undertaken by junior doctors working on the wards.

At this inspection we also inspected the substance misuse services provided. We do not currently rate substance misuse services. We found the following issues that required improvement in this service:

- Staff did not always assess patients fully prior to undertaking medically assisted withdrawals. Staff did not always ensure that they explored all areas of risk that could be affected by the detoxification programme or complete brief cognitive assessments. This meant patients may be at risk of not receiving appropriate support.
- Staff did not always ensure that they sufficiently recorded the decision making process for the administration of medicine to a patient. The lack of recording of the decision-making process meant that the patient could be at risk of not receiving the correct medication in order to stop the progression of alcohol withdrawal symptoms.
- Staff did not always ensure that they risk assessed patients who had or were in contact with vulnerable children and adults.

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- Staff did not always ensure they calibrated all equipment.

However, we found the following areas of improvement:

- Following a previous serious incident at the hospital, the provider stated that admissions to Garden Wing and West Wing should not take place out of hours as there was reduced access to regular skilled staff, including medical staff compared to usual working hours. They had identified this as a risk to patients and outlined it in their action plan. At this inspection, out of hours admissions were still taking place. This was due to some patients turning up later than the agreed admission time. There were measures in place to ensure these admissions took place safely.
- At the October 2016 and August 2017 inspections, we found there was no system in place to monitor waiting times for new patients to be assessed by nursing and medical staff from their time of arrival on the ward. At the November 2017 inspection, we found the provider was monitoring the time new patients waited before staff completed a full initial assessment on admission to the acute wards.
- At the August 2017 inspection, we found on Upper Court and Priory Court staff had not always accurately recorded patients' physical health observations as prescribed or escalated physical health observations when they should have been. At the November 2017 inspection, we found that improvements had been made. We reviewed six records and saw that scores had been accurately recorded and doctors were notified when deterioration in physical health was indicated.
- At the August 2017 inspection, we found that that the nasogastric feeding rooms on Priory Court and Upper Court did not provide safe and clean environments. At the November 2017 inspection, improvements had been made. Priory Court's environment was visibly clean and there was adequate space on Upper Court for staff to prepare the nasogastric feeds.
- At the August 2017 inspection, we found a number of out of date items in the emergency bags on Priory and Upper Court. At the November 2017 inspection, improvements had been made on both wards and emergency medicines and equipment were fit for purpose.
- At the August 2017 inspection, we found that staff lacked an understanding on how to use and calibrate blood glucose monitoring machines on a daily basis. At the November 2017

inspection, nursing staff had received training in this area and additional nursing staff had been booked onto future training sessions. Records demonstrated daily calibration of the blood glucose monitoring machines.
- At the August 2017 inspection, we found out of date items out of in the emergency bag on Garden Wing. At the November 2017 inspection, we found that checks were in place to monitor the contents of the emergency medicines and equipment, and we did not find any out of date items.

However, we found these areas of good practice:

- All patients had current risk assessments, and those we checked were detailed and clear. Staff had undertaken training in relational security, and found this helpful in working on the wards. Extra staffing on all of the acute wards enabled more observations and interactions with patients, so that patients felt better supported.
- Staff on Lower Court had taken a proactive approach to ensure temporary staff were familiar with the ward. They had made a one-page document that outlined top tips for working on a CAMHS ward.

Are services effective?

Good

We rated effective as good because:

- We found an improvement in the quality of care plans across the acute wards, with greater evidence of patients' involvement in these. On East Wing staff attended two care planning meetings weekly, to ensure that all care plans were clear, accurate and up to date.
- Staff had undertaken training in meeting patients' physical health needs, and care records included details of appropriate support with these identified needs.
- Staff in the service maintained effective relationships with other services and organisations.
- Staff received regular management and clinical supervision and appraisals. They told us that they received appropriate support from their line managers, and the quality of training provided was high.
- Patients had access to a range of psychological therapies, including dialectical behavioural therapy, cognitive behavioural therapy, life skills coaching and psychodynamic approaches. In the early stages of admission, patients tended to join creative groups and activities.

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- There were systems in place to ensure that patients detained under the Mental Health Act, were made aware of their rights, and received appropriate advocacy.

However, we found the following areas needed for improvement:

- Not all care plans on the eating disorder wards were updated following a change in the patients' circumstances.

At this inspection we also inspected the substance misuse services provided. We do not currently rate substance misuse services. We found the following issues that required improvement in this service:

- Medical staff did not always complete good quality initial assessments and carry out the appropriate physical health checks in accordance with National Institute for Health and Care Excellence (NICE) guidance.
- Staff did not always ensure that prior to treatment commencing and during admission patients completed alcohol and drug testing.
- Nursing staff supporting patients with substance misuse had not received specialist training in substance misuse. Some staff did not have a good understanding of the tools used to monitor patients. Following our inspection, the provider implemented a new nursing competency checklist.

Are services caring?

Good

We rated caring as good because:

- Patients spoke positively about staff interactions with them, and we observed staff engaging with patients discreetly and respectfully. Patients on Garden Wing particularly appreciated the extra staff provided on the female corridor, who was available to talk with them.
- The hospital provided young people on Lower Court with cordless Bluetooth headsets. This was because headphones with cords were banned due to ligature risk. Staff recognised the importance of music to young people, especially in times of distress.
- There was excellent involvement of young people on Lower Court. Patients sat on CAMHS staff interview panels and were involved in the development of their therapeutic programme.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

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- At the previous inspection in August 2017, we identified concerns about the safety on Garden Wing, largely as a result of patients, visitors and staff passing through this ward to reach other parts of the hospital. At this inspection steps had been taken to improve the safety of the ward such as two additional staff worked during the day to monitor access to the ward and to observe and engage with patients in the corridor leading to the garden area. Despite these measures, staff continued to walk through Garden Wing to access other areas of the hospital. This compromised the privacy and dignity of patients on the ward.
- In August 2017, we found the dining room on Upper Court was too small and did not provide a positive therapeutic environment for patients with an eating disorder and that some patients were eating in a restaurant area next to the Garden Wing. At this inspection, the work was still not complete and was agreed to be completed by the end of August 2018.
- In August 2017, there was no suitable environment for the physical examination of patients on Garden Wing, other than patients' bedrooms. Following the inspection, the provider had committed to plans to provide an examination room by 31 August 2018.
- The grounds of the hospital were not adequately lit after dark. This meant that staff and patients may be at risk of trips or falls.
- Patients told us that there were insufficient activities available on the acute wards on Sundays.
- Since the last inspection we found the following areas of improvement:
- In August 2017, we found that the nasogastric feeding rooms on both wards were decorated in a way that was not therapeutic to patients. At the November 2017 inspection, improvements had been made. Staff held consultations with patients to see how they wanted to decorate the rooms. The interior design team aimed to complete this by December 2017.
- In August 2017, we found that there was no de-escalation/ self-soothe room available and no privacy for patients who were distressed on Priory Court. At the November 2017 inspection, we found that work was in progress and a revised completion date for December 2017 had been set due to building contractor delays.
- Following a previous serious incident at the hospital, it was agreed that admissions should not take place out of hours as there was access to more regular staff in usual working hours including medical staff. At this inspection, staff on the Garden

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Wing and West Wing said that out of hours admissions were taking place, this was due to patients turning up to the hospital after the agreed admission time. There were measures in place to ensure these admissions took place safely.

- We found the following areas of good practice:
- Patients had access to a range of psychological therapies and creative groups and activities. These included arts and crafts, music sessions, mindfulness, reflection and support groups, problem solving, goal setting, creative expression, and therapeutic reading.
- Patients particularly appreciated the hospital gym and were satisfied with the hospital accommodation.
- There were systems in place to learn from complaints across the hospital.
- Patients on the private wards were able to continue to attend therapy sessions at the service after discharge from the hospital.
- Patients said the food was of a good quality.

Are services well-led?

Good

We rated well-led as good because:

We found the areas of improvement since the last inspection:

- At the October 2016 and August 2017 inspections, we found that log-in details of permanent staff were being shared with agency staff. At the November 2017 inspection, we found that this was no longer happening.
- At the October 2016 and August 2017 inspection, we were concerned that staff on the wards were not aware of contingency plans to address unexpected downtime of the computerised records system. At the November 2017 inspection, staff on all wards were clear about action to take in the event of computer outage.

We found the areas of good practice:

- The hospital had a strong and responsive leadership. Since the last inspection in August 2017, the provider had demonstrated that they had taken our concerns seriously and put forward an action plan that demonstrated short and medium term actions to improve the safety of their patients.
- Staff told us that senior managers were visible on the wards, and found them approachable. They described improvements since the previous inspections, particularly having more staff on shift on the wards, to provide safer care for patients.

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- There had been many changes to policies and processes since our last inspection. Staff had the opportunity to contribute to discussions about the strategy for the service. For example, the proposed environmental changes.
- The CAMHS and eating disorder wards had participated in relevant national accredited schemes, which helped them improve the service they provided to patients.
- The ward was involved in the new models of care pilot project in CAMHS, which was led by two London NHS trusts.

At this inspection we also inspected the substance misuse services provided. We do not currently rate substance misuse services. We found the following issues that required improvement in this service:

- The provider did not robustly monitor the quality of the service provided in the substance misuse services. It had not identified the areas of concern we identified. At this inspection, we found that staff in the substance misuse services did not all have the necessary knowledge to support patients undergoing medically assisted withdrawals. They did not complete full assessments for patients prior to their undergoing treatment or monitor them in accordance with the tools they were using.

Detailed findings from this inspection

Mental Health Act responsibilities

- We do not rate responsibilities under the Mental Health Act 1983.We use our findings as a determiner in reaching an overall judgement about the Provider.
- At the time of our inspection there were 24 patients detained under the MHA across five of the six inpatient wards at the hospital. Most patients were detained prior admission to the hospital.
- There was a MHA administrator based onsite. Staff knew how to contact them for advice where necessary. The MHA administrator visited the wards on a daily basis to ensure that duties under the MHA were completed and documented. We found that there was a robust process in place for ensuring that MHA responsibilities were fulfilled and documented accurately. We found on Garden Wing for one patient, a section 2 had been allowed to lapse before an assessment was requested to consider an application for section 3.
- Staff explained patients' rights under the MHA to them routinely and had access to an independent mental health advocacy service. Staff undertook training on the MHA as part of their mandatory training.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training in the Mental Capacity Act 2005 (MCA).
- Staff understood the principles of the MCA (which is applicable to people over 16) and supported patients to make decisions. Staff confirmed that capacity was assumed unless proven otherwise. For example, we saw that where patients had been admitted informally a comprehensive capacity assessment had been undertaken and the records detailed that they had consented to admission, treatment and some of the restrictions applicable to the service.
- We saw detailed records relating to the assessment and understanding of capacity across the service, where decision specific assessments had been made and the best interests of the individual considered.
- Staff on Priory Court and Lower Court had an understanding of Gillick competence, which is where a person (under 16 years of age) is assessed and deemed to have the competence to make decision about their own care, without the need for parental consent. Competency of patients was clearly assessed and recorded.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Specialist eating disorder services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Substance misuse/ detoxification	N/A	N/A	N/A	N/A	N/A	N/A
Overall	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

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

Requires improvement

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

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

Requires improvement

Safe and clean environment

Safety of the ward layout

- The current layout of the three acute wards presented potential risks to the safety of the patients admitted to these wards. The risks to patient safety were greatest on East Wing which the layout over four floors made it hard for staff to observe the multitude of risk areas, but were also present on West Wing and Garden Wing including in the garden areas. The potential risks were a result of poor lines of sight and the presence of multiple ligature points.
- The hospital was working to mitigate these risks through a number of measures. The consultants reviewed the appropriateness of the admissions to the current ward environment before they were agreed. Staffing levels on the acute wards had increased and on Garden Wing they helped monitor access to the ward. Also levels of observation were agreed for patients on an individual basis and access to additional staffing could be arranged. Staff had also received training in relational security.
- The acute wards had safe rooms which had been refurbished to provide a high level of ligature safety and were located near to the nurse station. The hospital had also worked with an external company to develop camera surveillance. Staff had worked with the company to position cameras in areas of heightened risk. These sent messages to mobile devices held by a staff member on the ward. Cameras could be turned on in patient bedrooms with their consent. These cameras had been installed in the designated 'safer room's on Garden Wing and in the corridor, which was not easy to observe by staff. On Garden Wing the cameras were due to be operational in November 2017. On West Wing, two male bedrooms located down a small flight of stairs, and two female bedrooms opposite the mixed gender lounge, had been closed until CCTV cameras were installed.
- Despite all these mitigations and some on-going work to improve the existing safety of the wards the current environments were not suitable for adults with acute mental health needs. The hospital had recognised this and had stated its intention to relocate the service on East Wing and completely redevelop the West Wing and Garden Wing environments. Clear timescales were not yet in place for this work. The East Wing service needed to be relocated as a matter of urgency and the provider needed to review if they could continue to provide a safe service on West Wing and Garden Wing until the redevelopment work had been completed.
- Staff had easy access to alarms they could activate in an emergency. A monitor showed staff the location of an emergency when the alarm was activated. We saw staff responding to alarms promptly.

Maintenance, cleanliness and infection control

- The wards were visibly clean and well maintained, and during the inspection we observed housekeeping staff on each ward, completing their duties.
- Regular infection control audits were undertaken with action plans in place for completion. We found that the

most recent actions identified had been completed and cleaning records were kept as appropriate. The ward manager on East Wing was the infection control lead for the hospital.

- On East Wing, following work to improve the safety of the environment including boxing in exposed pipes and cables, work was needed to redecorate the ward. The provider had plans in place for this to be completed, and the ward manager advised that patients were to be consulted about their preferences for the colour schemes.

Clinic room and equipment

- At the August 2017 inspection, we checked the emergency bags on the acute wards and found two items out of date on Garden Wing. During the November 2017 inspection, we found that checks of all emergency and clinical equipment had been added to the shift coordination document on each ward, so that a particular member of staff was allocated to this task to ensure it was completed. We found that the emergency bags kept in the nurses offices, were checked regularly for contents and expiry dates, and that this was recorded. All items were within the date of expiry.
- There was a clinic room audit file on each ward, with checks undertaken by nursing staff, including daily and weekend duties. The ward managers checked that these duties were being undertaken and recorded.
- We found records that equipment had been calibrated, with stickers used to record the date of calibration. As required at the inspection in August 2017, by November 2017 staff had received training in calibration of blood glucose measuring equipment.

Safe staffing

Nursing staff

- In August 2017, overall agency staff usage for the hospital had dropped, but we found high use of unfamiliar agency staff on weekend shifts on Garden Wing. This meant that the hospital did not ensure that consistent care and treatment was provided to patients during weekend shifts when unfamiliar agency staff were used. There had been an improvement in shifts across the acute wards having the required level of staffing. The hospital had introduced three-month contracts for agency staff to ensure staff were familiar with the ward.
- At the November 2017 inspection, we found that agency staff who were new to the wards, or had not been to a particular ward for some time, completed a detailed ward induction on arrival for their shift. The induction was recorded and signed by staff involved. However, there was a high turnover of staff on Garden Wing, with 50% of staff leaving in 2017 by November. At the time of the inspection, out of an establishment of 10 nurses, and 10 health care assistants on Garden Wing, there were vacancies for one health care assistant and two nurses (with a further four nurses leaving in the next month). There was an acting ward manager and no deputy manager in post. Although, there was an ongoing active recruitment programme in place, there was an issue of high turnover of staff on the ward. On East Wing out of an establishment of 10 nurses, there were four nurse vacancies.
- Staff on all wards said that baseline staffing levels had increased since the August 2017 inspection. This made it easier for them to provide safe care and treatment to patients. Staff felt better supported and safer as a result. This had resulted in an increase in the use of bank and agency staff in the interim period, particularly at night. However, wards were using staff on three-month contracts where possible, to provide greater continuity of care to patients.
- Ward staffing levels were set according to the number of patients admitted to a ward. During the inspection, we saw that the wards were staffed according to these calculations. A designated bleep holder on shift on each ward responded to emergencies on other wards when required. Although there was a high use of bank staff and agency workers, fewer shifts were understaffed since the previous inspection. On Garden Wing in the three months to November 2017, the ward was understaffed on nine shifts, on West Wing on three shifts, and no shifts were understaffed on East Wing.
- Ward managers were working to produce staffing rotas twelve weeks in advance on Garden Wing and West Wing, and fourteen weeks in advance on East Wing, to ensure the continuity of permanent staff over weekends and at night. On Garden Wing patients gave positive feedback about the impact of having a staff member positioned and available to interact with them on the female corridor.

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

Requires improvement

- Monthly sickness rates on each ward varied in 2017 peaking at 19% on East Wing, 16% on Garden Wing, and 16% on West Wing.

Medical staff

- Each consultant psychiatrist had a weekly ward round. There were ward rounds on two days weekly on East Wing, with the ward covered by one consultant. However, Garden and West Wing had a large number of consultants (up to 13) with ward rounds.
- Each ward had a junior doctor who provided medical cover to patients during the day. Outside office hours, a duty doctor based on the site was available on-call. There was a locum doctor provided by an agency on the hospital site out of hours in the evenings and at weekends. Since the August 2017 inspection, an extra doctor was scheduled to work at weekends, so that there were two on duty during the day. The out-of-hours doctors usually worked for a period of one week at a time. The locum out-of-hours doctor remained on site when on duty. There was a consultant psychiatrist on call out of hours. Locum doctors were provided with log-ins to allow them to access the electronic records.
- There was no system in place to monitor the training undertaken by locum doctors and junior doctors on rotation. One doctor told us that they had not received breakaway training in over 18 months.

Mandatory training

- Ward managers monitored mandatory training figures for eligible staff. Training rates were higher than at the previous inspection, although this was a challenge for ward managers due to a significant turnover of staff. Training in rapid tranquilisation was at 87% for permanent staff, and 84% for all staff (including bank staff).
- Mandatory training rates on all wards were at 75% or above, with the exception on Garden Wing, where there was a training rate of 72% for safeguarding children and young people.
- Staff we spoke with told us they were up to date with mandatory training. They had recently undertaken two training sessions in relational security, and were awaiting further training in this area.

Assessing and managing risk to patients and staff

Assessment of patient risk

- At the October 2016 and August 2017 inspections, we found there were gaps in physical health assessments, and monitoring of patients vital signs following rapid tranquilisation. This meant staff may have not promptly identified deterioration in patients' physical health following rapid tranquilisation, and contravened the provider's policy. At the November 2017 inspection, we found that since the August inspection, there had been one incident of rapid tranquilisation on Garden Wing, and three on East Wing. Staff were using a rapid tranquilisation tracker to record all incidents. This included prompts to record relevant observations including blood pressure, pulse, respirations, temperature, and hydration. In each case we found that the patients had refused observations, and only a sedation score was recorded. Staff made repeated attempts to record observations. In one case on East Wing, whilst recorded on the rapid tranquilisation tracker, there was no entry regarding the incident in the patient's care notes. We brought this to the attention of the ward manager, who undertook action to ensure this was corrected.
- At the October 2016 and August 2017 inspections, we found there was no system in place to monitor waiting times for new patients to be assessed by nursing and medical staff from their time of arrival on the ward. At the November 2017 inspection, staff were using an admission tracker to record waiting times for all new patients before having a full assessment by a doctor or nurse. The vast majority of assessments took place within the provider's target of one hour. There were no breaches on West Wing, one wait of four hours on Garden Wing, and three breaches on East Wing (including one of 8 hours, following a risk assessment, because the patient had arrived in the night, and wished to sleep) since the previous inspection. Despite the provider's attempt to limit this, following the learning from a serious incident, there were admissions on the private wards (Garden and West Wing) after 6pm.
- We found appropriate risk assessments for patients prior to admission, and staff told us that they could refuse admission, if unable to support a patient's needs on the ward. Staff risk assessed all patients and assigned a risk rating of red, amber or green – and set an observation level according to the level of risk identified. Records showed that staff carried out risk assessments on a standard form for all patients on admission and updated these assessments frequently.

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

Requires improvement

Management of patient risk

- Risk assessments were linked to risk management plans that included the frequency of observation, and ways of addressing anxiety and challenging behaviours.
- Four levels of observation were available, ranging from constant observation (with a member of staff within eyesight of the patient at all times) to intermittent observations either twice or four times each hour, and general observations involving hourly checks. Nurses could increase the observation level but only a doctor could authorise a reduction. Restricted items, such as razors and plastic bags, were stored securely.
- We observed staff using handover meetings to share important information about patients with the on-coming shift. Staff completed handover sheets as a written record of the information handed over. Staff handed over the current risks affecting patients so that all staff were aware of them.
- There were blanket restrictions agreed for each ward, depending on the risks to patients, and these were kept under review.

Use of restrictive interventions

- In the six months prior to the November 2017 inspection, there were four incidents of restraint on Garden, and West Wings respectively. On East Wing there had been 26 incidents of patients being restrained over this time period, including one incident of prone (face down) restraint, for the purpose of rapid tranquilisation.
- Staff told us that they were trained in de-escalation skills, which involved staff responding to patient's agitation by talking to them and understanding their concerns. They advised that they used physical restraint only as a last resort.

Safeguarding

- Staff were trained in safeguarding, knew how to make an alert and did so when appropriate. Staff told us that they knew how to identify adults and children at risk of significant harm, working with other agencies when required.
- A social worker at the hospital was the designated safeguarding lead. Staff said they had a good relationship with the local authority safeguarding team. The hospital safeguarding lead carried out a quarterly review of safeguarding activities. The report of this review provided details of themes that had developed and any lessons learned.
- Staff followed safe procedures for children visiting patients in the hospital. Patients were able to book a private family room for such visits.

Staff access to essential information

- At the previous inspections in October 2016 and August 2017, staff were not clear about how to obtain log–in information for agency staff working on the wards. At the November 2017 inspection, staff were clear about procedures to obtain these log-ins, and advised that they had not given their log-in details to any other staff to use.
- Staff used a combination of paper and electronic patient records. All information needed to deliver patient care was available to relevant staff, including agency workers.

Medicines management

- Medicines were stored in a safe manner and staff recorded their administration. Staff checked medicines room and fridge temperatures on the acute wards daily and temperatures recorded were within appropriate limits. The wards kept records of medicines and health care products regulatory authority drug alerts for staff to refer to.
- For medicines prescribed to be given when required, there was insufficient information available to staff on which dose should be administered. On some occasions we saw that patients were given moderate to high doses when the record charts only showed mild symptoms. No record was made about how this decision was made.
- On Garden Wing, we found that in two recent cases, staff had not completed records of medicines given to patients to take with them on home leave. Staff were recording take home medicines on East and West Wings.
- There was an appropriate, easy to use system in place for administration of medicines, and staff audited medicines every weekend. However two patients told us that agency staff had mistakenly given them incorrect medicines, which were only corrected after they raised concerns. We were unable to corroborate these incidents as they were not recorded as near miss incidents.

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

Requires improvement

- An external pharmacy audited patients' medicine administration records at least weekly and sent the results of the audits to ward managers. If errors were identified these were addressed with the individual staff concerned. For each medicine, there was a record of the start date, frequency, route and amount prescribed for the patient. Management assessed nurses each year in respect of their competence to administer medicines safely.

Track record on safety

- On the acute wards there had been six serious incidents in the previous 12 months. These included three patient incidents involving use of a ligature.
- Staff received a debrief session after incidents, and patients were offered a debriefing session.

Reporting incidents and learning from when things go wrong

- Team meeting minutes on the wards showed that the staff team discussed learning from incidents and safeguarding concerns.
- Staff told us about changes that had been brought in following an incident involving hot water, on one ward, following which patients had access to a drinks machine instead of a kettle. Other changes following incidents included carrying out more random searches, use of sniffer dogs, and arranging for increased observations of patients promptly when agitated, to prevent escalation to an incident.
- Staff were aware of their duty of candour, to inform a patient if an error was made in their care or treatment.
- We reviewed records and learning from incidents on each ward. Some of the recent lessons learned were not completed in detail. However, the ward managers advised that these would be signed off by a senior manager who would make amendments as needed.
- A learning outcomes group took place on a weekly basis, during which staff discussed learning from incidents and complaints from all wards across the hospital.
- Following the receipt of a coroner's report relating to a death at the hospital in 2015, the provider had increased the frequency of ligature and blind spot risk assessments, commenced weekly quality walk-arounds, and introduced observational competency checklists for new staff and agency workers.
- The physical health lead and other ward managers carried out simulations of emergency situations on each other's wards, to ensure that staff were practiced in actions to take in an emergency, including use of a resuscitation doll.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Staff completed a comprehensive mental health assessment on new patients, soon after admission, and also assessed physical health needs.
- We reviewed 12 patient care records, ten of which were detailed and clear. We found that all patients had 'keep safe' care plans that outlined their needs and current experiences, and included up to date incidents. Depending on patients' needs, and how long they had been at the hospital, care plans were put in place for keeping well, keeping healthy, keeping connected, and for special arrangements.
- Care plans showed patient involvement in their development, when patients had chosen to be involved, and patients were offered a copy of their care plan.
- Care plans were audited regularly by ward managers as part of weekly quality walk-arounds. On East Wing, staff attended twice weekly care plan meetings to ensure that all care plans were reviewed and up to date. Staff said that they found these meetings helpful. The ward manager gave out regular prizes to the staff members who had produced care plans with the most patient involvement.

Best practice in treatment and care

- In addition to prescribed medicines, the wards offered a range of psychological therapies including dialectical behavioural therapy (DBT), cognitive behavioural

therapy (CBT), life skills coaching and psychodynamic approaches. This complied with NICE (National Institute for Health and Care Excellence) guidance on provision of positive psychology based therapies. In the early stages of admission, patients tended to join creative groups and activities. When they were ready, they engaged with more complex therapeutic groups, such as DBT. The wards recorded the Health of the Nation Outcome Scale (HoNOS) for each patient. Staff used patient health questionnaires and generalised anxiety disorder tools, but there was no formal monitoring of the effectiveness of therapies on the wards.

- The provider allocated link therapists to each consultant for consistency, and so that they could participate in ward rounds as needed.
- The acute wards had incorporated 'safewards', a model aimed at decreasing incidents of violence and aggression on wards using different interventions. On East Wing, we saw that a 'hope tree' was in use, with a patient being discharged during the inspection completing a leaf for this tree. At the community meeting, the ward manager advised that a second tree would be made for patients at an earlier stage in their journey to recovery. Self-soothing boxes and dialectical behaviour therapy were also available on this ward.
- A calendar of health care audits was in place for the hospital, including an annual audit on reducing restrictive practice. Nursing staff told us they had been involved in audits of clinical practice in relation to physical health observations, risk assessments, consent to treatment and medicines.
- The ward manager on East Wing was the physical health lead for the hospital working alongside a doctor in this role. He had recently provided four days of physical health training to staff members, with more sessions planned. The training included understanding the importance of physical health for mental health patients, care planning, managing diabetes, glucose monitoring and calibration of equipment. Training included hands on experience in taking physical health measurements, including blood pressure, and an electrocardiogram, physical observation competencies, and recording. The importance of vital signs observations and recording after rapid tranquilisation were covered. The training also included neurological observation, and support with the symptoms and possible complications of mental health and other long-term conditions, such as tuberculosis and chronic obstructive pulmonary disease.
- The physical health lead conducted monthly simulations for staff on the wards, accompanied by the management of violence and aggression trainer. Learning from these simulations included improved staff access to keys to patients bedrooms.
- Staff on East Wing said that the use of a modified system for recording physical health monitoring was now fully embedded in ward practice. Staff told us they carried out weekly checks of patients' vital signs as part of regular physical health monitoring. Staff carried out checks more frequently when patients had identified physical health needs or risks. Health care assistants had received training in how to assess patients' vital signs.
- The hospital was not a smoke free environment and staff were not aware whether the provider had plans to address this. Staff offered nicotine replacement therapy to patients who smoked. Patients were offered smoking cessation advice.

Skilled staff to provide care

- Staff said they had good access to a range of training in addition to their mandatory training, with a mixture of face to face, and online training offered. Health care assistants were supported to apply for nurse training. On East Wing, one health care assistant was undertaking occupational therapy training, and another was due to undertake a training course in personality disorder awareness. Six staff were undertaking the care certificate qualification on East Wing, with five on West Wing and Four on Garden Wing.
- All staff, except one, said they received regular supervision. Staff received monthly external supervision to discuss clinical matters. They also received monthly managerial supervision from their line manager. One health care assistant said they did not need formal managerial supervision and accessed this on a day to day basis as needed. All staff said they had received an annual appraisal.
- A staff support group facilitated by a psychologist was available to staff from all wards on a weekly basis. Staff told us that they felt better supported since there was

an increase in staffing on the acute wards. This also meant that they were moved to work on other wards less frequently, an issue which they had found particularly stressful.
- New staff said that the induction training provided was helpful including mandatory training, relational security, and awareness of the importance of boundaries.

Multidisciplinary and interagency team work

- Wards had multi-disciplinary teams that included nurses, health care assistants, psychologists, psychotherapists, occupational therapists, consultant psychiatrists and ward doctors. Up to 13 consultant psychiatrists referred and covered patients on Garden and West Wings. One consultant psychiatrist covered East Wing. A pharmacist visited each ward twice weekly. On Garden Wing and East Wing, staff noted that the absence of a ward clerk for over a year placed an additional burden on them.
- Handover meetings took place twice a day when the shifts changed. Detailed information was provided on new patients and a specific list of tasks was agreed for the shift.
- Patients saw a doctor at least once a week for a ward round meeting including members of the multi-disciplinary team. Staff told us there were good relationships within the teams. On Garden Wing staff said that they needed a room for multi-disciplinary meeting, and this was planned as part of the redesign of the ward in the forthcoming year.
- East Wing maintained relationships with the referrers of their NHS patients, inviting them to care programme approach meetings to discuss discharge and future care. Staff informed referrers of any incidents involving the person they referred.
- There was a social worker in place for the hospital. There were two occupational therapists based on Garden and West Wings, and half a full time post for occupational therapy provision on East Wing.
- A psychology assistant worked on East Wing, and several different assistant psychologists worked on Garden and West Wings, attached to different consultants.
- Each ward had a programme of therapies available for patients including psychology, mindfulness, cognitive behavioural, psychoanalytic, eye movement desensitisation and reprocessing, family therapy, and bereavement counselling. On East Wing, due to shorter and unpredictable stays by patients (who might be recalled by the NHS), sessions focussed on psycho-education.
- There had been some gaps in staff team meetings on the wards, due to recent staffing issues. Instead of being held weekly, these were held approximately fortnightly on East Wing, and less frequently on Garden Wing. In addition, monthly business meetings took place on each ward. On East Wing, the multi-disciplinary team attended twice weekly care planning meetings, and NHS business meetings were also attended by members of the senior management team.

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

- Staff completed online training on the Mental Health Act (MHA) part of the Priory Foundations for Growth training programme. Compliance rates were 100% for Garden Wing, 94% for East Wing and 95% for West Wing.
- When the hospital required a patient to be assessed under the Act they made a referral to the approved mental health professional duty service at the London Borough of Wandsworth. Staff told us that this service was quick to respond.
- The MHA administrator ensured medical and nursing staff scrutinised MHA paperwork. All original paperwork is kept in the administrator's office with copies uploaded to the electronic record and kept on a paper file on the wards. Copies of certificates of consent (T2) and certificates of second opinion (T3) were kept on the medication charts of qualifying patients.
- The MHA administrator ensured nurses and medical staff complete a checklist of tasks, relating to the MHA for each patient including scrutiny of documentation, explaining section 132 rights to patients and repeating them at regular intervals. They also noted expiry dates so that reminders could be sent to the responsible clinician, and provided reminders for completing consent to treatment authorisations under section 58 of the MHA, including making referrals for second opinion appointed doctors (SOADs). A separate spreadsheet relating to the completion and review of initial assessments of capacity to consent to admission and treatment was kept by the governance and audit co-ordinator.

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

Requires improvement

- Staff told us that the MHA administrator visited the wards on a daily basis to ensure that duties under the MHA were completed and documented.
- Our scrutiny of the documentation found that there was a robust process in place for ensuring that MHA responsibilities were fulfilled and documented accurately. On Garden Wing, one patient's detention under section 2 of the MHA had been allowed to lapse before an assessment was requested to consider an application for section 3. This had been raised as an incident and addressed as soon as the issue was identified, and the patient was informed.
- There were two mental health advocacy services at the hospital, including statutory provision for detained patients, requested when needed, and another informal advocacy service which visited patients on the wards weekly. We met with a statutory independent mental health act advocate visiting a patient on East Wing. They told us that staff were good at requesting their services when needed, but patients sometimes found the presence of two advocacy services confusing.

Good practice in applying the Mental Capacity Act

- Staff completed online training in the Mental Capacity Act. Compliance rates were 100% on East Wing, 95% on West Wing, and 94% on Garden Wing.
- Medical staff carried out mental capacity assessments for patients on admission, assessing the capacity of patients to give consent. Records showed that staff considered the four components of mental capacity, to ensure that patients had consented to treatment.
- Nurses on the wards told us that doctors considered mental capacity of patients at weekly ward rounds. They explained that if patients did not have capacity to consent to admission or treatment, and that inpatient treatment is necessary for the health or safety of the patient, they would make an application for detention under the Mental Health Act.
- There had been no applications for deprivation of liberty safeguards. Staff on East Wing told us about how they had used the Mental Capacity Act to support a patient with diabetes, who did not have capacity to consent to treatment.

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

Good

Kindness, privacy, dignity, respect, compassion and support

- Since the August 2017 inspection, the trust employed two extra health care assistants on each day shift on Garden Wing, and one at night. One of these staff was responsible for responding to the door buzzers, and monitoring people coming in and out of the ward. The other staff member was available to monitor and support patients on the corridor furthest away from the ward office.
- During the November 2017 inspection, we observed staff interacting with patients in a discreet, respectful and caring manner. Patients told us that they felt safe on the wards, and found staff supportive on an individual basis and the groups helpful. Patients on West and Garden Wing valued the opportunity to attend day-groups within the service after discharge from the hospital, providing them with continuity of support.

Involvement in care

Involvement of patients

- Patients attended regular community meetings on each ward, approximately weekly. The East Wing community meeting minutes showed that concerns about the ward raised by patients were recorded and addressed. Where complete remedy was not possible, or there were delays to repairs, staff explained why this was the case and kept patients updated. Some recent actions taken following meeting included repairs, purchasing a new games console, and improving communication between ward and therapy staff.
- We attended a community meeting on East Wing, attended by patients and staff including the ward consultant. During the meeting, staff gave an update on actions from the last meeting, and the ward manager read out new entries in the ward's suggestion box and comments book. The catering manager attended, in

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

Requires improvement

response to some comments about food at the last meeting. Patients gave their views on what worked well, and what they wanted to change about the menus, and catering service to the ward.

- On Garden Wing, there had been longer gaps between recent community meetings as these overlapped with a new reflection group which the patients valued. The ward manager told us that they were reviewing the timings of these groups. Patients told us that they appreciated the new reflection group held each evening on the ward, to 'check in' with how they were.
- Patients received a welcome pack in their bedrooms on admission, including details about ward routines, and relevant contacts. The contact details of the advocacy service were displayed on the ward notice boards.
- Patients told us that they were involved in their care plans and assessments, and offered a copy. Three patients told us that staff could improve their communication with them during the day and night, particularly when agency staff were on shift.

Involvement of families and carers

- Patients were able to meet with their family members, including booking a private room to spend time with their children.
- Staff gave information to family members or carers only with the consent of each patient and were able to provide information about advocacy and support networks available to them.

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

Requires improvement

Access and discharge

Bed management

- Average bed occupancy on East Wing was 71% with patients staying an average of 17 days. On Garden Wing bed occupancy was 63% with an average of 22 days stay, and on West Wing this was 59% with an average stay of 23 days.
- There was always a bed available when patients returned from leave, and patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in their best interest.
- Following a previous serious incident at the hospital, the provider stated that admissions to Garden Wing and West Wing should not take place out of hours as there was reduced access to regular skilled staff, including medical staff compared to usual working hours. They had identified this as a risk to patients and outlined it in their action plan. At this inspection, out of hours admissions were still taking place. This was due to some patients turning up later than the agreed admission time. All patients were assessed prior to admission and the provider ensured they had full referral details and risk assessments.
- The bleep holder reviewed all new referrals for admission. Referrers completed a risk assessment document prior to admission.
- There were no specific catchment areas for the wards. Most patients were from London and the South-East of England.

Discharge and transfers of care

- Staff responded to increased agitation by increasing levels of observation of patients. If a patient required psychiatric intensive care, they would need to be discharged to another hospital, as this was not provided at the Priory Hospital Roehampton.
- NHS patients on East Wing were frequently recalled on Thursdays and Fridays, prior to the weekend.
- Staff planned discharges and they took place during the day.

Facilities that promote comfort, dignity and privacy

- At the previous inspection in August 2017, we found that patients on Garden Wing did not have access to private areas, and this compromised patients' dignity. At the October 2016, and the August 2017 inspections we found that on Garden Wing, there was regular flow of staff and patients from other wards accessing the dining area through the ward. This impacted negatively on the privacy and dignity of patients. Prior to the August 2017 inspection, the hospital put a protocol in place to manage traffic through Garden Wing including a designated walkway for patients and staff to use as an

alternative route to the dining room. However, this was not effective, and staff and patients continued to use Garden Wing as a thoroughfare. This compromised the safety, privacy and dignity of patients on the ward.

- During the November 2017 inspection, we found that the provider had made changes to the access arrangements to Garden Wing. Staff actively challenged non-ward staff who requested entry to the ward and redirected those who could use alternative access arrangements to staff dining room and therapies area. This significantly reduced the number of people walking through the patient lounge area. However, during the inspection we observed five staff enter and walk through the ward on their way to different destinations. A number of staff and patients had to access areas of the ward to reach therapy rooms. However, plans for redesigning the ward environment included creating a separate corridor that would avoid the need for this access to the ward. The plans also included producing a more private lounge area in place of the open plan area at the time of the inspection.
- At the August 2017 inspection, we found that there was a new clinical room on East Wing, for patients to receive physical examinations. However, there was no clinical room available on Garden Wing, meaning that patients received physical examinations in their bedrooms. Following the inspection, the provider produced an action plan including the planned redesign of Garden Wing by 31 August 2018, included providing a new clinic room which could be used for physical examinations. The plans also included a new nurses' office, a multi-disciplinary meeting room, a female lounge, and more private general lounge.
- Patients had access to hot drinks and snacks when they wanted, and access to a garden. At the time of the inspection in November 2017, the garden on East Wing was temporarily closed while the fence was made more secure.
- Patients had access to their bedrooms, including secure storage for their valuables, when they wished, although they were encouraged to attend their therapeutic programmes. They spoke highly of the gym facilities available.
- The catering manager attended community meetings on wards where patients had raised issues with the menus or food service.
- Five patients on Garden Wing complained about a lack of internet access on the ward. This had been raised at community meetings, and the provider was looking at ways to improve Wi-Fi provision across the hospital. The provider had installed Wi-Fi boosters around the hospital. However, due to the nature of the building, some areas received poor connectivity and patients were able to move to areas of greater activity. They also expressed concerns about the lounge area on Garden Wing, which was open plan and could therefore not be used during the night without disturbing patients in bedrooms nearby. This issue was due to be addressed by the proposed redesign of the ward in the forthcoming year.

Patients' engagement with the wider community

- Staff supported patients to maintain contact with their family members, and people that mattered to them.
- Patients on Garden and West Wings had the opportunity to continue attending therapy sessions at the hospital after discharge.

Meeting the needs of all people who use the service

- A chaplain was available for patients to contact. Monthly meetings were held in the chapel. Information about where to obtain religious and spiritual support was displayed on ward noticeboards. Staff could also support patients to attend places of worship of their choosing.
- The service could produce leaflets for people whose first language was not English and provide interpreters although staff said this was not usually required.
- Leaflets on health promotion were available to patients. Information was also provided on safeguarding, making a complaint, contacting the Care Quality Commission and accessing advocacy.
- Patients told us that the food provided was of a high standard and met their individual and cultural needs. Two patients said that there should be more organic and vegan options.
- Patients were generally satisfied with the therapies and activities available to them. There was a weekend programme in place from Monday – Saturday. However, four patients said that there were not enough activities available on Sundays.

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

Requires improvement

- On East Wing, staff provided groups including sensory integration, distress tolerance skills, assertiveness, goal setting, cognitive behavioural therapy (CBT), mindfulness, relaxation, and a moving on group. Activities included attending the gym, a trip to the supermarket, arts and crafts, and music sessions. Staff did not provide formal activities at the weekends, but supported patients with 'weekend planning,' and a reflection group after the weekend.
- Garden and West Wings shared activities. The low intensity programme included problem solving, goal setting, creative expression, therapeutic reading, and behaviour activation. Longer cognitive programmes also included coping strategies, CBT for anxiety, depression and obsessive compulsive disorder, art therapy, drama therapy, solution focussed therapy, assertiveness, a family programme, gender support, bereavement, and dialectic behavioural therapy.

Listening to and learning from concerns and complaints

- Patients knew how to complain or raise concerns. In the 12 months prior to the inspection, there were nine complaints received from patients or their relatives on Garden Wing, of which two were upheld, and one went on to the ombudsman. On West Wing, there were four complaints in this time period, of which one was upheld. On East Wing, one complaint was made in this time period, and was not upheld.
- The main themes of complaints made included the use of agency staff, and staff attitude. There was one complaint about the admission process, and one complaint about the hospital management of a patient who absconded.
- Ward managers told us about changes that had been made as a result of complaints, including providing staff with customer care training, and in one case, staff disciplinary procedures.
- Two patients told us that they or their family members had recently made a complaint to the provider via their website, but had not received a response. One patient told us that they had made a complaint; staff had listened to them, and taken action to address their concerns promptly.

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

Good

Leadership

- Staff said senior managers were very visible in the hospital, regularly visited the wards and knew who staff were. Staff believed they were committed to improving standards of care and treatment and the environment.
- Ward managers and directors met on a daily basis for a brief meeting to discuss any immediate concerns or incidents. These were known as 'flash' meetings. Senior staff also conducted regular 'quality walk arounds'. This enabled managers to check the environment, and carry out checks on the quality of patient care.
- The acting manager on Garden Wing had not yet been provided with leadership training.

Vision and strategy

- Staff were familiar with the organisational values, in particular the importance of putting patients first.
- The objectives for each ward reflected these values. These objectives were to provide a safe environment, to be caring and supportive towards patients, and to promote recovery.

Culture

- Staff knew how to raise concerns about patient safety and the quality of care. When they had raised concerns they had felt listened to and action had been taken by senior staff to address the concerns.
- Staff said that the teams worked well together, and described a particularly supportive team on East Wing. A student described East Wing as a good learning environment. A suggestions' box was used to thank staff and could nominate staff member of week.
- The morale of staff we spoke with was generally good and they were positive about changes taking place in the service. We asked staff to explain the high turnover of staff on Garden Wing (10 staff leaving in 2017 and a further four staff leaving in the next month). They

suggested that the high turnover was due to meeting patients' expectations, pressure rather than support from management, and the high number of different consultants, leading to staff 'burn out.'

- The hospital had worked towards improving staff morale by holding 'You Say Forums' to encourage staff engagement and keep them informed in regards to staffing. The provider used a 'morale-o-meter' whereby a survey was sent to all staff members to gain feedback on staff morale.

Governance

- The senior management team governed the hospital. This included the hospital director, the medical director, and the clinical services directors. The hospital was taking steps to recruit to vacancies and increase retention of staff. Agency staff were employed on three month locum contracts to ensure greater consistency in the staff working on the wards.
- The ward managers told us they had sufficient authority to make decisions about staffing levels and felt supported by the clinical services directors.
- Staff were involved in clinical audits such as audits of ligatures, care plans, safeguarding and restraints. There were well established systems in place for the reporting of incidents and complaints and discussing lessons learned with the staff team. There were also clear procedures in place for the use of the Mental Health Act, Mental Capacity Act and making safeguarding alerts.
- Key performance indicators included recruitment and retention of staff, compliance with mandatory training and completion of outcome measures. Data on these indicators was provided to ward managers in a table that enabled them to monitor their performance.
- At the previous inspection in August 2017, there was no system in place to monitor how long patients were waiting for assessments on admission. At the November 2017 inspection, an admission tracker had been put in place to monitor waiting times for assessments, indicating that the target of an assessment within one hour was largely met.
- The hospital had a governance system in place to assess and monitor the quality and safety of care and treatment provided to patients. A learning and outcomes group met monthly and discussed all incidents and complaints that had occurred or been received in the service, and ensured that the duty of candour was met. Weekly compliance meetings were also held. These meetings fed into the monthly clinical governance committee meetings.
- The clinical governance committee monitored all safeguarding incidents, learning from serious case reviews and other incidents, infection control, health and safety, equipment, medicines, staffing, and staff training compliance. They also reviewed all complaints, and monitored use of restrictive practices, nutrition, policies and procedures, clinical records, health promotion, compliance with the Mental Capacity Act and Mental Health Act and staff supervision and appraisals. They looked at compliance with internal and external inspections, feedback from staff and patient meetings, and other audits.
- Managers conducted patient focussed, physical health and environmental quality walk arounds on wards, to ensure a high standard of care for patients.
- A 'flash' meeting took place in the hospital every morning on weekdays, with a manager or representative from each ward. Ward representatives reported back to the senior managers and other staff present on the number of incidents that had occurred on their respective wards and reviewed staff numbers for that day and night. Where staffing shortfalls were identified, plans were put in place to obtain more staff or staff were moved from other ward rotas if they had more than the required number of staff.
- The provider's quality development programme for 2017 included a focus on multi-disciplinary working, medicines management, shift management, leadership, and preceptorship. It also included further implementation of positive behavioural support, relational security, safe wards, safer staffing, and the role of the speak up guardian.

Management of risk, issues and performance

- The provider maintained a risk register for the hospital, which the management team reviewed at compliance and senior management meetings. Staff could submit items to the hospital risk register through the clinical governance meeting.
- Issues on the risk register included the safety of the ward environments and staffing challenges.

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

Requires improvement

- Ward staffing levels were determined by a 'staffing ladder' tool dependent on the number of patients on the ward. Staffing levels could be increased should the acuity of the ward require it.
- Staff received training in prevention and management of violence and aggression, and conflict resolution.
- Since the August 2017 inspection, the provider had introduced an admission tracker to monitor patients' wait for an assessment on admission, and a rapid tranquilisation tracker, to ensure that patients' vital signs were monitored after its administation.

Information management

- At the October 2016 and August 2017 inspections, we found that log-in details of permanent staff were sometimes shared with agency staff. This meant that any entries made by that temporary staff member would be attributed to the permanent staff member. At the November 2017 inspection, we found that staff were aware of how to obtain log-in details for agency staff and did not share their personal log-in details with any other staff.
- At the October 2016 and August 2017 inspections, we were concerned that staff on some of the wards were not aware of contingency plans to address unexpected downtime of the computerised records system. At the November 2017 inspection, staff advised us that they would contact the bleep-holder. This was in line with the provider's policy, following which a laptop was available and couriers could deliver dongles if needed.

Engagement

- Patients were able to give anonymous feedback about the wards. On East Wing, feedback posted in a comments box on the ward was read out in community meetings and staff took action to address the concerns where possible.
- Senior managers conducted a monthly review of service user feedback from surveys.
- Every ward had a staff representative. Ward staff representatives met with staff from human resources every month at a staff forum. This enabled staff to raise any concerns that they or their colleagues had. 'Your say forums' were also held periodically to encourage staff engagement in the running of the hospital.
- Staff advised that team meetings were often cancelled on the wards due to insufficient staff available, but generally felt supported by ward management. A facilitated staff support group was held every week.
- Staff told us they felt able to raise any concerns they had with their line manager. Staff felt that there had been significant changes in the hospital since the last inspection.
- Management fed back to staff on the results of the most recent 'morale-o-meter' in July 2017, including some positive comments about changes, but some reports that staff still felt unheard and insufficiently supported.

Learning, continuous improvement and innovation

- The hospital had installed a movement-activated system on each ward, following a pilot on West Wing, in order to provide extra protection for high risk areas in the environment, and assist with quality assurance.
- Staff were receiving training in relational security, and told us that it had changed the way they thought about risk on the wards. They had incorporated 'safewards' a model aimed at decreasing incidents of violence and aggression on wards using different interventions. On East Wing a second 'hope tree,' was planned for patients at an earlier stage in their journey to recovery. Self-soothing boxes and dialectical behaviour therapy were also available on this ward.

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Good

Safe and clean environment

Safety of the ward layout

- Lower Court provided care and treatment for up to 12 children and adolescents experiencing an acute episode of mental illness. The ward was set out across two floors. There were seven bedrooms on the lower floor and five bedrooms on the upper floor.
- Staff completed regular risk assessments of the care environment. The health and safety lead had recently completed a generic risk assessment for the whole hospital. In addition, the deputy ward manager on Lower Court then completed additional risk assessments specific to the ward. For example, separate risk assessments for the garden and the self-soothe room, which clearly identified risks and actions to mitigate them.
- During our last inspection of the ward in February 2016, we found there were some blind spots on the ward and there were no convex mirrors to address then. At this inspection, we found improvements had been made and all rooms had convex mirrors. The ward had completed an up to date blind spot audit.
- The ward had a separate CCTV system that monitored areas of potential risk, in communal areas and bedrooms. The cameras would only be turned on in bedrooms with patient or parental consent. The cameras were monitored by an external body and alerted staff on a hand-held device when ligature anchor points were tampered with. This system helped to ensure the safety of patients who were at high risk of self-harm or suicide.
- The ward had an up to date ligature risk assessment that identified ligature anchor points. A ligature anchor point is an environmental feature or structure, which patients may fix a ligature with the intention of harming themselves. The ward manager shared the risk assessment with staff at team meetings. Staff had access to a ligature management folder that had detailed information regarding potential ligature anchor points across the ward and how staff should mitigate ligature points. Ligature cutters and scissors were clearly displayed in the nursing office for easy access.
- Since the last inspection of the ward in February 2016, the hospital had installed three 'safer' bedrooms on the ground floor. Patients who were deemed high-risk of self-harm could use these rooms for their safety. These rooms had reduced ligature furnishings and were completed to specification. The hospital had also completed anti-ligature work on the other bedrooms so that they all had magnetic en-suite bathroom doors, an anti-ligature radiator cover and non-weight bearing curtains.
- Senior management carried out regular environmental quality walk arounds on the ward. Records showed that the hospital director had completed an environmental quality walk around on Lower Court in September 2017. This ensured that senior management had a good understanding on the safety of the environment on the ward.

- The ward provided care that supported patient's privacy and dignity. The upper floor was single gender and patients shared two bathrooms. The lower floor was mixed sex accommodation, but all bedrooms had en-suite bathrooms.
- Staff allowed authorised individuals onto the ward. Visitors signed in before entering the ward.
- Nursing staff carried out daily security checks of the environment at the start of each shift. These checks included checking bins did not have plastic bags as these were a banned item on the ward.
- Ward based staff had appropriate access to alarms, which worked throughout the ward. All members of staff had a personal alarm and activation panels were placed throughout the ward. Staff were also provided with radios. Records demonstrated that the radios were checked on a daily basis. These checks formed a wider a security check whereby nurses checked medication keys and alarms were in working order.
- Patients had easy access to nurse call systems, which were located in communal areas and patient bedrooms.
- Each patient had a personal emergency evacuation plan (PEEP). The PEEP is an individualised plan to ensure the safe evacuation from the ward in case of an emergency. Staff sent the plans to the reception daily so they were aware of patients' needs in the event an emergency. The hospital had a major incident contingency plan in place, alongside a major incident policy.
- The health and safety lead completed regular fire checks of the hospital. These included weekly fire testing and fire extinguisher checks, and monthly fire drill evacuations and emergency lighting checks. We saw records that demonstrated these happened regularly. The hospital had taken a proactive approach to fire safety and had booked a three-day fire inspection for the week after our inspection. The hospital had an up to date fire safety policy in place.

Maintenance, cleanliness and infection control

- The majority of the premises were clean and tidy, and the ward was comfortably furnished. However, two young people we spoke to raised concerns in regards to the cleanliness of the ward, in particular the kitchen area at weekends. We observed that the surface area in the kitchen, including the chopping boards, was dusty, and the hot plate was unclean with food debris. The clinic room couch, first aid and equipment boxes were dusty. The recent infection control audit identified cleanliness issues surrounding clinic room, lounge, bedroom, bathroom, meeting room and kitchen cleanliness.
- The hospital had allocated a cleaner to the ward, who cleaned the ward three times a day, after breakfast, lunch and dinner. We checked the cleaning records for the ward. Records were up to date and demonstrated that the ward was cleaned regularly. However, for the kitchen, there was no space to document the cleaning of the hot food plate, which staff used to serve the young patients' food.

Seclusion

- There was no seclusion room on the ward.

Clinic room and equipment

- Staff had access to a clinic room on the ward. The clinic room was fully equipped with accessible resuscitation and emergency drugs that were all in date and checked regularly.
- The clinic room fridge was clean and only contained in date medication. The fridge and clinic room temperatures were checked on a daily basis and were within normal range. Senior management noted that there had been issues with the clinic room temperature as being too high in the summer months due to a heatwave. We were told an air conditioning unit for the clinic room had been approved, but the ward was waiting for an installation date. This issue had been identified on the hospital risk register. In the interim, a mobile air conditioning unit had been placed in the clinic room and it was being monitored by the pharmacist to ensure safe storage of medicines.
- Medical devices (blood pressure machine and weighing scales) were available and portable appliances tested appropriately. The hospital had an agreed contract with an external provider that had the responsibility to service clinical equipment. Records demonstrated clinical equipment had been serviced recently. At our last inspection of the hospital in August 2017, we found that staff lacked an understanding of how to use and calibrate blood glucose monitoring machines on a daily basis. During our inspection, we found some

improvements had been made. The ward manager and the deputy ward manager had now completed the hospital's new physical health training, which covered the calibration of medical equipment.This training was being rolled out monthly to ensure all staff had the necessary training. We found that staff were checking calibration of blood glucose monitoring machines on a daily basis.

Safe staffing

Nursing staff

- Although the ward had staffing vacancies, managers planned for this and ensured that there was sufficient staff on duty to safely deliver care. Data provided by the hospital showed that between August 2017 and October 2017, the ward was fully staffed 97% of the time during day shifts and 95% during night shifts.
- There were five nursing vacancies. The hospital had recruited into two of these nursing posts, but they had not started at the time of the inspection. The hospital had an ongoing programme of recruitment whereby senior management held qualified nursing interviews every Thursday at the hospital. There were no healthcare assistant vacancies at the time of our inspection. Staff highlighted staffing as a risk and the difficulties around hiring nurses on a permanent basis. Staff felt it was hard to find nurses who had an interest in children's and young people's services as well as the skills to work on the ward. Staff felt this affected morale as workloads had increased and led to working extra unpaid hours to ensure work was being completed. Staff were mixed on the impact of staffing on patient care. Some staff said staffing led to nurse burnout but did not affect patient care, but some nurses felt that they increasingly missed out on interactions with patients as a result of this and the increased paperwork.
- Until nursing vacancies were filled, the hospital used bank and agency nurses to cover the vacancies and maintain safe staffing levels**.** Data provided by the hospital showed that between August 2017 and October 2017, bank and agency usage on the ward was high. Bank and agency filled 20% of day shifts and 67% of night shifts. This indicated almost all night shifts were covered by bank and agency. The data showed only 11% of the night shifts had a permanent nurse on shift and that there were five occasions where no permanent nurses or healthcare assistants covered night shifts.
- Senior management were aware of the high bank and agency usage and recognised concerns around consistency of care. The hospital had recently introduced three-month contracts for agency staff to ensure staff were familiar to the ward. The ward manager also kept a list of bank and agency staff that had worked on the ward previously and were familiar to the patient group and ward. The associate director of clinical services supported ward managers with their rota planning to ensure where possible, shifts were covered by permanent staff. Staff discussed the weekend rota in the Friday morning 'flash' meetings to check familiar staff were working on the these shifts.
- The ward tried to hire bank and agency staff that were familiar with the ward. However, this did not always happen. As a result, permanent staff ensured temporary staff received an induction. This included a tour of the ward and review of ligature anchor points and blind sports. There was also an observation competency checklist to ensure staff could safely carry out the observation of patients. The nurse in charge signed off the induction and observation competency checklist.
- Staff on the ward had a proactive approach to ensure sure temporary staff were familiar to the ward. They had produced a one-page document that outlined tips for staff working on a CAMHS ward. This document was clearly displayed in the nursing office.
- The staff sickness rate in the last 12 months was low at 7%. The staff turnover rate in the last 10 months was low at 5.5%.
- The managers had calculated the number and grade of nurses and healthcare assistants required. The ward had two shifts: day and night. The day shift had two qualified nurses and two healthcare assistants. The night shift had two qualified and one healthcare assistant.
- A qualified nurse was present in communal areas of the ward at all times. Patients we spoke to confirmed this

was the case. Staff and patients said no escorted leave or activities had been cancelled because of staff shortages. Staff made an effort to ensure these always happened regardless of staffing issues.

- Patients had a qualified named nurse and a named co-worker, who was a healthcare assistant. Staff informed patients of this on admission and let them know who they would be.

Medical staff

- The ward had adequate medical cover during the day and at night.A responsible medical officer provided cover out of hours and was supported by an on call CAMHS consultant.

Mandatory training

- The ward's overall compliance rate for mandatory training in September 2017 was high at 99%. The provider's target rate for compliance with mandatory training was 92%. The ward had exceeded the provider's target rate in all 28 areas, apart from fire safety, mental capacity act training and prevent training. The lowest compliant rate was 82% for prevent training. Prevent training aimed to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves. Managers monitored mandatory training compliance rates and reminded staff to keep up to date.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We reviewed six care records. These records demonstrated staff completed risk assessments on admission and updated them on a regular basis, for example, after an incident. The provider used a recognised risk assessment tool. Staff screened patients for different risks such as suicide, self-harm, substance misuse and disinhibited sexual behaviour. Risk management plans were detailed, comprehensive, individualised and demonstrated engagement with the patient.

Management of patient risk

- Staff identified main risks as physical and verbal abuse from patients, inappropriate and challenging behaviour and the environment.
- Patients were not allowed unsupervised access to the second floor. This was due to the ward layout not allowing staff to safely observe all parts of the ward. When patients accessed the staircase and upper floor, a member of staff was present at all times. Because of this, some patients felt this resulted in later bed times due to staffing issues. This was highlighted to senior management during the inspection, who were aware of the issue as patients had raised this issue in a community meeting. Senior management were looking at different ways to try to manage the issue.
- Where staff had identified potential risk, plans were in place to manage and mitigate these. Staff used ward rounds, handovers and team meetings as places to discuss and identify new and existing risks. Staff updated risk management plans in both the electronic patient records and risk management folders individualised to patients.
- During our inspection, we observed that staff were a visible presence across the ward. Staff conducted security ward checks to ensure patients did not have contraband and conducted intermittent observations. Staff discussed levels of observation at wards rounds and team meetings and appropriately adjusted this depending on the outcome. However, a patient we spoke to felt observations were irregular and informed us they could self-harm as a result. We escalated this to senior management during inspection.
- The ward had justified restrictions on certain items on the ward. Patients were not allowed to use phones between 9-5:30 to encourage attendance at both groups and education sessions. Patients could use the phone on the ward within these hours if they wished to contact family or friends. Other restricted items included chewing gum and lighters.
- The hospital had restrictions regarding smoking, which was not allowed on the wards. Young people were advised on admission that smoking was prohibited on the wards.
- Young people admitted to the ward informally were aware of their rights to leave the ward. Staff considered the risk to patients before leave and where appropriate contacted parents of the patients. We spoke to an informal patient who was aware of their rights to leave the ward and could do so.

Good

Child and adolescent mental health wards

Use of restrictive interventions

- There was no seclusion room on the ward. Staff said there had been no use of inappropriate or de facto seclusion on the ward. Staff attempted to verbally de-escalate situations before restraint was used.
- Upon admission, patients and their therapist put together a personalised self-soothe box. These boxes contained items that the patient found calming and were used during times of distress. We reviewed a self-soothe box. It contained items such as herbal teas, stress balls and family photos. The self-soothe box was based on dialectal behavioural therapy principles.
- Every restraint was classified as an incident. The hospital had provided staff training in prevention and management of violence and aggression (PMVA). This helped staff manage situations that involved conflict and aggression. All staff on the ward had completed PMVA breakaway training. The hospital had recently introduced relational security training. This training looked at professional boundaries between staff and patients and appropriate responses. Six staff members on the ward had completed it and additional staff were due to complete it.
- There were 65 uses of restraints between April 2017 and September 2017, which involved 14 different patients. The high number of restraint was due to one young person being particularly unwell and requiring a higher level of restraint to ensure their safety. This patient had since been moved to a more acute mental health facility. One incident resulted in prone restraint along with rapid tranquilisation. During our inspection, we found there had been a second incident of prone restraint on October 2017. For these two prone restraint incidents, we were told the patients had put themselves into the prone position when staff attempted to intervene. The hospital discouraged staff to use the prone restraint unless it was deemed in the patient's best interest. These incidents of prone restraint were raised as incidents and investigated by senior management, which was in line with their policy on prevention and management of disturbed/violent behaviour.
- At the last inspection in August 2017, the provider had failed to ensure that staff completed physical health assessments and monitored vital signs for all patients following rapid tranquilisation. Since the August 2017 inspection, records showed that staff used rapid tranquilisation by intra-muscular injection nineteen times on two different patients on Lower Court. We reviewed all 19 records, which demonstrated staff had completed the appropriate physical health assessments and monitoring after each incident. Staff used a rapid tranquilisation observation chart to record vital signs, which was in line with NICE guidance. Each time there was an incident of rapid tranquilisation on the ward, ward managers recorded it on a rapid tranquilisation monitoring tool, which was reviewed daily by senior management.

Safeguarding

- Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate. Staff could identify children and adults at risk of abuse.
- Training in safeguarding was mandatory. Compliance for safeguarding children training was 94% and safeguarding vulnerable adults was 94%. The hospital had a safeguarding policy in place.
- Staff gave examples of when they escalated a safeguarding concern, for example, patients at risk of sexual or physical abuse. Staff received support in safeguarding from a safeguarding lead who worked across the hospital. The safeguarding lead was the hospital's child protection lead and attended patient meetings on the ward when required. The ward complied with Local Safeguarding Children Board procedures and appropriate national guidance, such as The Children's Act. The safeguarding lead worked closely with the local authority to safeguard and promote the welfare of the young people. The lead completed a yearly safeguarding audit for Wandsworth child protection.
- The ward was securely separated from the adult wards in the hospital.

Staff access to essential information

- All information needed to deliver patient care was available to all relevant staff when they needed it and was in an accessible form. Electronic records contained,

Good

Child and adolescent mental health wards

risk assessments, care records, progress notes and evidence of physical health observations. Staff also had access to a paper record system. Staff we spoke to did not experience difficulties access any of the systems.

Medicines management

- The provider had a medicines management policy. Good medicines management processes were in place and followed by staff. There was good practice for receiving, storing and administering medication.Staff had access to medicines disposal facilities, including sharps bins which were all dated appropriately. We reviewed all twelve patient's medication charts and found there were no gaps. Disposal records were completed by two staff members. We found controlled drugs were managed safely and stock balances were correct.
- The majority of liquid medicines had their date of opening recorded, but we found three medicines that did not. We also found nine out of the twelve patients did not have photographs on their medication cards. This was raised with staff during the inspection who said they were in the process of getting the photographs completed.
- Staff reviewed the effects of medication on patient's physical health regularly. Where a patient was receiving clozapine therapy, we found safe management of their physical health, with regular blood tests.

Track record on safety

- There had been 21 serious incidents in the last 12 months that required investigation. These incidents included young people absconding from the ward, damage to ward property and medication overdoses.
- Staff were able to describe recent serious incidents on the ward and across the provider. These included verbal and physical abuse to staff, medication incidents and incidents where patients absconded. Staff described common themes amongst incidents, for example patients locking themselves in bedrooms, head banging and damage to ward property.

Reporting incidents and learning from when things go wrong

- Staff recorded incidents on an electronic record. They classified incidents as being serious if they involved a patient absconding, sustaining a significant injury, or if they needed to report the incident to the Care Quality Commission. For these incidents, staff completed a 'Situation, Background, Assessment, Recommendation' (SBAR) form. This system allowed staff to quickly organise key information about an incident and present it in a consistent format. All SBARs were sent to the Priory Group head office to ensure oversight.
- Staff were debriefed and supported after a serious incident. Debriefs described areas where staff did well or areas for improvement. Feedback was also disseminated to the team through emails. Staff gave an example of feedback involving a patient who had absconded and how senior managers praised them on how well they had dealt with it.
- Staff debriefed patients following serious incidents. For example, we saw evidence that this happened following a serious incident in November 2017.
- The hospital ensured learning from when things go wrong. All staff were received a learning lessons email, which shared learning from incidents across the Priory hospitals. We saw an example, which shared an incident from Lower Court, where a patient had used a food item to conceal a sharp object. Staff on the ward were able to talk about changes made to the patient search process in response to this incident.
- Following the receipt of a coroner's report relating to a death at the hospital in 2015, the provider had increased the frequency of ligature and blind spot risk assessments, commenced weekly quality walk-arounds, and introduced observational competency checklists for new staff and agency workers.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed six patient records, which demonstrated staff completed a comprehensive and timely assessment of patients soon after admission.

- Staff conducted physical health checks on admission and staff continuously monitored this throughout the duration of patient admissions. Staff monitored patient's vital signs when necessary. For example, a patient on the ward had recently started a trial of the antipsychotic medication clozapine. Staff conducted baseline physical health observations, including bloods and recorded them in the patient's care record.
- Care plans were holistic, personalised and demonstrated discussion of patients' diagnoses, goals and interventions. Care plans included sub care plans that addressed different aspects of the patients' objectives, for example, physical health, safeguarding and restraint. The care plans were regularly reviewed and updated and included outcomes of discussions with patients. Patients' views were clearly documented in their care plans, and where patients were too unwell to understand their care plan staff had recorded this clearly.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patients. The therapies provided by the multidisciplinary team were delivered in line with guidance from the National Institute for Health and Care Excellence.Patients had access to a wide range of psychological therapies. For example, the clinical psychologist ran a dialectical behavioural therapy based group programme, which focussed on mindfulness and emotional intelligence. Other therapies included family therapy, music therapy, drama therapy and cognitive analytical therapy. Staff also offered patients one to one individual support.
- The occupational therapist ran a programme for young people that supported activities of daily living. This included exercise, cooking, interpersonal skills and games groups. Young people had been given the creative opportunity to choose the names of activities and groups, for example, they had named a group "totes emosh". This group involved exploring different emotions.
- Patients attended a school on site during the week. The school liaised with each patient's own school to facilitate continuing education. Ofsted inspected the school in November 2016 and rated the school as good overall.
- Assistance with physical healthcare was provided by nurses and the duty doctor when required. When patient required a specialist treatment for their physical health, staff supported patients to a local acute hospital. Staff could refer patients to the onsite dietician if there was an identified diet need. The hospital had recently introduced physical health care training to ensure staff knew the different physical health care needs of people with mental health illness. It included information on smoking cessation and diabetes.
- Staff used recognised rating scales to assess and record severity outcomes. Staff used the Health of the Nation Outcome Scales Child and Adolescent Mental Health (HoNOSCA). The assessment focused on the young person's general health and social functioning. Staff used it to assess the severity of each issue at the beginning of treatment and at the end to measure whether there had been any improvement as a result of treatment. Staff also used the Children's Global Assessment Scale, which measured the young person's emotional and behavioural functioning.
- Staff on the ward participated in clinical audits. This included a monthly audit on patients' physical health care where staff checked patients' physical health care plans and whether patients' weights had been recorded. Nurses also completed an audit each weekend, which included documentation checks to ensure care notes had been uploaded.
- The hospital completed internal audits on safeguarding, infection control, risk assessments and ligatures, and also participated in a national audit on preventing suicide.

Skilled staff to deliver care

- The team had access to the full range of specialists required to meet the needs of the young people on the ward. The team included doctors, nurses, an activities co-ordinator, assistant psychologist, clinical psychologist, family therapist, CAMHS therapist, an occupational therapist and educational teachers. There was a 0.4 ward doctor vacancy on the ward. This was temporarily being covered by the ward doctor from the CAMHS eating disorder ward and agency medical staff. Senior management were aware of this vacancy

shortage and they discussed and arranged ward doctor coverage in the daily morning 'flash' meeting. These meetings were attended by ward managers and directors.

- Staff were experienced and qualified, and they had the right skills and knowledge to meet the needs of the patient group. The nursing team was varied in their skill set. In addition to the registered mental health nurses, there was a registered paediatric general nurse and a registered learning disability nurse. The paediatric nurse had only recently started, but there were plans for them to take the lead for physical health care on the ward.
- Patients had access to the hospital's sessional therapists. These included the drama therapist, dietician and yoga teacher. If a patient had a substance misuse issue, staff were able to seek guidance
- Staff said they had access to specialist training. This included access to therapeutic training for healthcare assistants and dialectical behavioural therapy training for nurses.
- The hospital provided new staff with an official induction. New staff received a week-long induction to the hospital. This included training on risk management, supervision, health and safety, basic life support, safeguarding and managing violence aggression. This was then followed by a specific induction on the CAMHS ward, which was role-specific.Competencies would be signed off by the nurse in charge.
- Healthcare assistants completed the care certificate. This is a set of standards that health and social care workers should adhere to in order to ensure that they safely deliver their role.
- Staff received regular supervision. We reviewed 17 supervision records for staff on the ward and found the percentage of staff that received regular supervision in the last 12 months was 92%. Staff received additional clinical group supervision once a month, which was facilitated by an external healthcare professional.
- All staff eligible had completed an appraisal in the last 12 months.
- We saw evidence that managers dealt with poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

- Staff held regular and effective multidisciplinary meetings. Nursing staff held handovers twice a day between shift changes. In these meetings, staff discussed new admissions, discharges and incidents that had taken place during the previous shift. Handover notes were recorded electronically and we saw complete and comprehensive notes for the past month. Nursing staff completed a handover with the therapy team each morning on the ward. This ensured therapy staff were up to date on any incidents or risks. We observed the nursing team also complete a thorough verbal handover with the educational teacher ahead of school starting. This demonstrated effective information sharing about patients between different disciplines.
- Business meetings were held monthly. We reviewed the latest meeting minutes available on the system from August 2017. The meeting minutes were comprehensive and covered items such as vacancies, incidents and restrictive practice. Staff said they were always provided with meeting minutes via email if they could not attend.
- The safeguarding lead had good working relationships with Wandsworth local authority and was able to seek advice and assistance where needed.
- Staff felt they had a good working relationship with community mental health teams and care co-ordinators. Staff said they were in regular contact with different community mental health teams and encouraged care co-ordinators to attend six weekly care programme approach meetings. Staff said community mental health teams visited patients on the ward before their discharge to get to know them.
- The ward was involved in the new models of care pilot project in CAMHS, which was led by two London NHS trusts. Staff said they had weekly communication with the pilot leads.

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

- At the time of our inspection, there were five patients detained under the mental health act: three under section 3 and two under section 2. There were seven informal patients.
- All staff were trained in the Mental Health Act (MHA). Staff we spoke to had a good understanding of the MHA.

Good

Child and adolescent mental health wards

- The hospital had structures in place to ensure the safe and proper implementation of the MHA. The hospital had a full time MHA administrator who took the lead in MHA administration. The MHA administrator visited the ward on a regular basis to ensure that duties under the MHA were completed and documented. The hospital had robust process in place for ensuring that MHA responsibilities were fulfilled and documented accurately.
- The hospital demonstrated good sharing and learning around MHA practice. The MHA had recently attended a two day conference for MHA administrators across the Priory Group. There was a buddy system in place for the administrators and the MHA administrator was buddied with their equivalent at a Southern Priory hospital. There was an email group for MHA administrators and there was also a group lead for the MHA who was the company's director of nursing. Legal advice could be accessed via the MHA lead where necessary.
- Staff had easy access to MHA policies and procedures on their local intranet and there was a MHA folder for guidance in the nursing office.
- The hospital completed an annual MHA audit as well as monthly reports on MHA activity, which were discussed as a standing item at the monthly clinical governance meetings.
- When the hospital required a patient to be assessed under the MHA a referral was made to the AMHP duty service at the London Borough of Wandsworth. We were told that this service was quick to respond.
- Patients had access to a general advocate and an independent mental health advocate who visited
- Staff informed patients of their rights on admission. Patients we spoke with said they were regularly read their rights as informal and detained patients. We saw additional evidence of this in patients care records.

Good practice in applying the MCA

- 94% of staff were trained in the Mental Capacity Act (MCA). Staff we spoke to demonstrated a good understanding of the MCA.
- Staff we spoke to said they would contact the consultant psychiatrist or the mental health act office for advice on the MCA.
- For patients under the age of 16, staff applied the Gillick competency test. The Gillick competence is used by staff to decide if a child 16 years or younger is able to consent without the need for parental permission.
- Patients' capacity was discussed and recorded weekly in ward rounds. Medical staff recorded and updated capacity assessments clearly in patient records. For example, where staff had assessed a patient's capacity to make a specific decision.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

- We observed kind, positive and responsive interactions from staff. Staff showed compassion and an interest in patients' wellbeing.
- Staff supported patients to understand and manage their care, treatment and condition. We saw evidence that patients met with their multidisciplinary team weekly, where care and treatment was discussed.
- We saw evidence that staff directed patients to other services when appropriate. For example, staff referred a patient to the hospital's dietician when a diet need was identified.
- We spoke with three patients. They were complimentary of permanent staff and described them as fun, helpful and understanding of their needs. The patients were slightly more negative on temporary staff and described them as uninformed and unaware of the specific needs of patients.
- Earphones had been banned on the ward due to the ligature risk of the electrical cord. In replacement, the ward provided each young person with a cordless Bluetooth headset so the patients could listen to music as it had been recognised that patients used the music as a self-soothing technique.

Involvement in care

Involvement of patients

Good

Child and adolescent mental health wards

- Staff used the admission process to inform and orient young people to the ward. The ward also had a handbook for patients on admission. This included information about the staff team, access to therapy, medication, the advocate and what to expect on the ward.
- Patients said they felt involved in their care and treatment. This included weekly meetings with their name nurse where, for example, they discussed their welfare and updated care plans together. They also met weekly with their co-worker, usually a healthcare assistant, where patients received support in day-to-day activities. Patients attended weekly multi-disciplinary meetings to discuss their care and treatment. During these meetings the consultant psychiatrist reviewed the patient's medication, capacity, leave and observations, with the input of the patient and/or families. Patients were given an opportunity to fill in a form ahead of the multidisciplinary meeting, which included information of what went well for that week and any requests. This ensured the patients' views were heard.
- Staff involved patients in care planning and assessments of risk on a regular basis. Patients we spoke with said staff regularly reviewed their care plans with them. Patients said they had copies of their care plans, and records demonstrated this.
- At the last inspection in February 2016, staff did not always ensure that patient community meetings happened weekly as planned. During this inspection, we saw an improvement. Patients said community meetings occurred weekly and that actions from these meetings were followed up at the next meeting. Minutes from these meetings were clearly displayed on a communal notice board.
- Patients had re-named the activities in their therapeutic timetable, so they were accessible to young people. For example, music therapy was named "it's all about the bass" and the cooking group was named "bake off".
- Staff encouraged patients to give feedback about the ward. This happened mainly in community meetings and weekly multidisciplinary ward rounds. The ward demonstrated that they were responsive to patients' feedback. For example, patients had fed back to staff that they felt there were too many staff members in the weekly ward rounds and that they found it overwhelming. In response to this, the full multidisciplinary team now meet the day before the patient's ward round to discuss the patient's care and treatment. Only the consultant psychiatrist and a member of the nursing staff attend the ward round the following day with the patient to review their progress.
- Staff involved patients when appropriate in decisions about the ward. For example, in the recruitment of staff. Patients on the ward had been part of the interview process for the ward's activity co-ordinator.
- The nursing team held a monthly patient forum as a space for patients to provide feedback about the ward. Any issues raised that could not be resolved locally would be shared with senior management.
- Patients had access to an advocate and information regarding the advocate was clearly displayed on the ward and in the patient handbook.

Involvement of families and carers

- A handbook for families and carers included details about care and treatment during the first weeks of admission, observation levels and visiting times.
- We saw evidence of family and carer involvement in patient records. For example, their input was recorded in care plans and in weekly multidisciplinary ward round notes.
- Staff informed and involved families and carers appropriately. We saw an example in a patient's care record where it had been agreed between the carer and staff that a member of the nursing team would call the carer each day to update them on their child's progress on the ward. We also, spoke to a carer who said they felt involved in their child's care and treatment plan.

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

Good

Access and discharge

Bed management

Good

Child and adolescent mental health wards

- Lower Court was commissioned as a Tier 4 service to provide specialist in-patient care to young people who were suffering from severe and/or complex mental health conditions that could not be adequately treated by community CAMHS services.
- Most patients were admitted to the ward in crisis. When a referral was received, the ward manager liaised with the referring agency to agree a realistic timescale for admission. Members of the multidisciplinary team would also speak to the referrer to ascertain the patient's needs and the purpose of admission. The majority of patients were funded by NHS England.
- Between 1 April 2017 and 30 September 2017, the average length of stay was 91 days and the average bed occupancy was 90%.
- The ward did not admit patients to beds that were allocated to patients who were on leave. Where clinically appropriate, patients could have overnight leave for up to three nights to help them adjust to being out of hospital.
- When patients were discharged this happened at an appropriate time of day. The time of discharge was led by patients and families/carers. It was never during the evening or weekends.
- Management told us that there had been some difficulties in arranging beds in psychiatric intensive care units (PICU). If a patient was waiting for a PICU they would be placed on 2:1 observations.

Discharge and transfer of care

- During the past 12 months, there had been three delayed discharges. This included a patient on the ward at the time of our inspection. The delayed discharge was due to challenges with housing the patient in the community. Management had taken appropriate steps to try to discharge the patient and were working closely with social services to arrange suitable housing. The hospital reported delayed discharges to NHSE on a monthly basis, which included detail on the delayed discharge, progress made and the effect it was having on the patient.
- Staff planned for patients' discharge. All patients had a planned discharge date in their care records. Discharge was discussed regularly at patients' ward rounds and care programme approach meetings, and community mental health team staff and care co-ordinators were encouraged to attend.
- Staff supported patients during transfers between services. For example, if patients required treatment in an acute hospital or temporary transfer to a PICU.
- The service ensured young people who were nearing their 18th birthday were appropriately transitioned to adult services. At the time of inspection, there were no patients over the age of 18.The ward manager produced quarterly reports for senior management, which included information on young peoples' transition pathway into adult services.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Each patient had personalised their bedrooms where appropriate. We observed bedrooms that had personalised duvet covers, personal belongings such as photos and other items to help them feel at home.
- Patients had somewhere secure to store their possessions.
- Staff and patients had access to the full range of rooms and equipment to support treatment and care. This included a lounge, an activities room, a self-soothe room, a communal kitchen and a spacious clinic room with an examination couch.
- There was no specific room on the ward set aside for visitors. Patients said they saw visitors in their bedrooms or in the group therapy room. Visitors under 18 years of age were required to be accompanied by an adult.
- Patients could make a phone call in private and had access to their own mobile phones. The use
- Patients had access to outside space. The ward had a secure garden. Patients asked staff to access the garden and always one member of staff would be present in the garden when it was in use. Patients had access to the hospital's grounds, which had an outdoor green space.

Good

Child and adolescent mental health wards

- Patients were positive about the quality of the food and said they had choice. Patients did not have unsupervised access to the kitchen, but could ask to use the kitchen to make themselves a drink or a snack 24/7.
- Two activity co-ordinators worked across a part time post on the ward. They ran activities during weekday evenings and on Saturday and Sunday.Activities included a reading group, a music group, cooking and games.

Patients' engagement with the wider community

- Patients had access to education on site. Patients we spoke with were mostly positive about the about the education they received.
- Staff supported patients to maintained contact with their families and carers. Staff contacted them on a regular basis and encouraged their attendance at care programme approach meetings and ward rounds. One patient we spoke to said that after an incident that required them to attend A&E, staff had not contacted their parents until the next day.

Meeting the needs of all people who use the service

- The ward was unable to admit patients with mobility difficulties due to the environmental layout. This would be assessed upon referral and patients would be referred to other services that offered full disability access.
- Staff ensured that patients could obtain information on patient rights, the complaints procedure and treatment. This was clearly displayed on a notice board in the communal area. The information was clear and was accessible to young people. For example, the complaints procedure had been re-named to 'mumbles and grumbles' and re-written in a simpler format.
- The ward had a contract with an interpreting service and brought in translators for patient meetings when required.
- Patients were asked about their dietary requirements on admission. Vegetarian options were available and meals could be prepared in accordance with medical, religious and cultural needs. Staff could refer patients to an onsite dietician if required.
- Patients said they knew how to access support with spiritual and religious needs. A chaplain visited the ward to provide spiritual support. There was a chaplaincy leaflet displayed on the notice board giving details of monthly visits.

Listening to and learning from concerns and complaints

- Patients knew how to make a complaint and felt able to raise concerns with staff. Complaints posters were displayed throughout the ward. When patients complained or raised concerns they received feedback. Staff used the community meetings to feedback on general concerns that affected the whole ward.
- Staff we spoke with were aware of how to escalate and deal with a complaint. Staff dealt with complaints on both a formal and informal basis. Feedback and learning from complaints were discussed at team meetings.
- In the last 12 months, there had been three complaints on Lower Court. Two of these complaints had not been upheld and one had not been partially upheld. All three complaints were dealt with in a timely manner. All three complaints involved poor communication to patients and their families/carers regarding their care and treatment. Lessons learned related to staff improving their communication and better management of patient and carer's expectations in regards to care and treatment.
- The ward kept a compliments folder. This contained positive feedback from patients and families/carers about staff and the care and treatment they received.

Are child and adolescent mental health wards well-led?

Good

Leadership

- Leaders had the skills, knowledge and experience to perform their roles.
- Leaders had a good understanding of the services they managed. For example, senior management took part in regular quality walk rounds on the ward. These included

checks of the environment, patient documentation and patient physical health care. This ensured leaders had a good understanding of the ward and were able to deliver immediate feedback to staff so improvements could be made. It also meant senior management were visible on the ward. Patients and staff said leaders regularly visited the ward and were approachable. In particular, staff noted the support site manager visited the ward regularly to check on the health and safety of the ward.

- Leadership development opportunities were available. The previous ward manager on Lower Court had recently been promoted to the hospital's associate director of clinical services, which was a senior management role. This role involved overseeing clinical practice across the hospital.
- Leadership development opportunities were available for staff below team manager level. The charge nurse on the ward had recently been promoted to deputy ward manager, and the deputy ward manager had recently been promoted to ward manager. Many of the other staff we spoke to had recently been promoted to more senior positions on the ward. This included the senior health care assistant who had previously been a health care assistant and an assistant psychologist who had previously been a activities-coordinator.

Vision and strategy

- Staff knew and understood the hospital's vision and values. The hospital's vision and values were introduced to staff in their induction and were also clearly displayed on posters throughout the hospital. For example, striving for excellence and working towards quality improvement. Staff discussed core values in their appraisals and were expected to demonstrate how they applied the values in their work.
- Staff curated the ward's local objectives. These were set out yearly during the staff's team away day, which was led by the hospital's therapy manager. One of the ward's local objectives was around cohesive team working. Staff displayed a positive approach to team work and around working with children and young people.
- Staff had the opportunity to contribute to discussions about the strategy for the ward. Senior management held listening groups for the ward to gain views from staff regarding change that may affect them.
- Senior management had developed quality improvement objectives for the hospital to achieve. These included an objective to improve physical health care and well-being of patients. We found evidence of this being implemented on the ward, through quality walk arounds focussing on patients' physical health care.

Culture

- Staff felt respected, supported and valued. Both by their immediate team on the ward, other ward teams and senior management.
- Staff felt positive and proud about working for the Priory and on Lower Court. In particular, staff were proud about working with the young people on Lower Court and helping to make a positive difference to their lives. Staff were positive about their managers and felt valued and important to the team.
- Staff felt about to raise concerns without fear of retribution.
- Staff knew how to use the whistleblowing process. The ward had a whistleblowing poster in the nursing office, which detailed a whistleblowing helpline. The hospital had a whistleblowing policy.
- We saw evidence that managers dealt with poor staff performance when needed.
- Staff consistently said they worked well together as a multidisciplinary team. We observed good interactions between different disciplines, for example, between nursing staff and therapy staff. Staff reported mixed morale on the ward. Some staff said the morale was very good, but some staff felt the morale was sometimes low due to increased workloads for the permanent nurses. This had been due to the difficulties into recruiting qualified nurses into permanent posts. Despite this, the team had a positive outlook on the work they did on the ward.
- Staff appraisals included conversations about careers development. Staff told us about many examples where they had been promoted. For example, from healthcare assistant to senior healthcare assistant, and activities co-ordinator to psychology assistant.
- The ward's staff sickness was slightly lower than the average for the hospital.

- The hospital recognised staff success within the ward. In October 2017, the Priory Group held the Pride Awards 2017 where 27 awards were presented to people and teams from across the company. The deputy ward manager on Lower Court won the Pride Priory award for being positive.

Governance

- There were regular team and management meetings with a clear agenda. This ensured that essential information, such as learning from incidents, safeguarding and complaints, were shared and discussed. The ward manager attended the weekly learning outcome group (LOG) meeting. We looked at the minutes of these meetings for the previous month. Managers from other wards came together to discuss incidents and share learning from them. Safeguarding and serious incidents were also discussed. This meant, managers from across the hospital monitored and improved the service together.
- Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. There were systems of governance processes in the hospital for ward managers to monitor and improve their wards. For example, the ward managers monitored the use of rapid tranquilisation on the ward to ensure that it was safely carried out. All incidents were recorded onto the electronic online system, which the ward manager monitored.
- Senior management had oversight of the hospital's complaints. A complaints' register monitored formal complaints across the wards. It included information regarding date complaint was raised, name of investigator, date the holding letter and final response was sent, and lessons learned. The ward manager monitored informal complaints on the ward and stored these in a folder in the nursing office.
- The ward manager kept their own spreadsheet to monitor and ensure staff supervision was taken place on a monthly basis.
- The ward manager ensured daily audits were completed on the ward. This included clinic room checks, equipment and environment checks. Senior management took part in quality walk rounds with the patients on Lower Court. This included gathering feedback from patients about the quality of care and treatment they receive, their medication, staff attitudes, treatment programmes and the safety of the environment. The audits were sufficient to provide assurance and staff acted on the results when needed.
- Staff understood the arrangements for working in teams internally and with external agencies, to meet the needs of the patients. The hospital safeguarding lead raised safeguarding concerns with the local authority (LA). They had close links with the LA, who provided extra advice and/or assistance to safeguard vulnerable children from abuse. Patients attended the school on the hospital grounds. Staff had good working relations with educational staff, which ensured continuity of care for the patients.
- Senior management attended monthly clinical governance meetings. There was a clear agenda of what was discussed to ensure essential information was shared. For example, the risk register, serious incidents, staffing, safeguarding and audits were discussed and reviewed.
- The hospital's training policy did not outline the expectations for mandatory training and what specialist training was required to safely deliver care and treatment to a specialised patient group such as addictions or eating disorders.

Management of risk, issues and performance

- Staff maintained and had access to the risk register at ward and directorate level. Staff at ward level could escalate concerns when required. For example, the risk register was a fixed item at the weekly LOG meetings, attended by ward managers and senior management.
- Staff concerns matched those on the risk register, for example, the need for air conditioning in the clinic room, and the self-soothe camera, which had been vandalised in the self-soothe room. There were clear plans in place to rectify the identified risks. Senior management reviewed and updated the risk register in monthly clinical governance meetings.
- The provider had piloted and then arranged for the installation of surveillance cameras in communal areas and bedrooms on each of the acute ward. They had increased the safety specifications of 'safer rooms' and undertaken removal of some identified ligature points.

- The ward had plans for emergencies, for example, adverse weather or a flu outbreak. The hospital had a business contingency plan in case of an emergency. At the August 2017 inspection, we found that not all staff were aware of contingency plans to address unexpected downtime of the computerised records system. During this inspection, we found improvements had been made. Staff on Lower Court knew what to do in the event of an IT outage. Senior management advised that a laptop was available, and couriers could deliver dongles if needed.

Information management

- Staff were satisfied with the systems in place to collect data from wards, and had access to the equipment and IT needed to do their work. Information governance systems included confidentiality of patient records. In the August 2017 inspection, we found that some permanent staff shared their personal log-in details with agency staff. During this inspection, we found improvements. Ward managers were sent a weekly list of temporary log-ins for agency staff. Staff we spoke to were aware of the temporary log-ins that were to be issued to agency staff.
- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff used an online electronic system to record patient care and treatment plans, incidents and access policies.
- Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.
- Staff made notifications to external bodies as needed. Staff provided notifications on patients absent without leave, allegations of abuse and any incidents involving the police to the Care Quality Commission (CQC) as required.

Engagement

- Staff had access to up-to-date information about the work of the hospital, for example, through the intranet, bulletins and newsletters. Staff received a monthly learning bulletin, which shared lessons learnt from across the Priory Group. For example, there had been a recent lessons learnt bulletin shared regarding information governance. Staff told us they were sent minutes from weekly LOG meetings and monthly clinical governance meetings. Patients and carers could receive recent information about the hospital through newsletters and from staff at community meetings.
- Staff had opportunities to give feedback on the service. One example was through monthly 'your say forums' facilitated by senior management. A 'your say forum' meeting was held in August 2017, where a CAMHS staff representative raised concerns that the staff door that led to a fire door did not always automatically lock. We followed this up during our inspection, and found this issue had been resolved.
- Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients fed back on the service through the community meetings and carers could do this through the weekly carer support groups held.
- Managers and staff had access to feedback from patients and carers, and staff used it to make improvements. For example, patients took part in the quality walk round by the senior management by providing feedback about the service. For example, ward cleanliness and assessing the quality of the food. This feedback was passed onto staff to drive improvements.
- Staff completed staff surveys (morale-o-meter) to feedback on the quality of support they received from management. The results were fed back via bulletins.
- Patients and carers were involved in decision-making about changes to the service. Staff told us that hospital's senior leadership team where open to engagement with patients and relatives when requested.
- Senior management engaged with external stakeholders, such as commissioners. Ward managers were expected to provide reports to the commissioners to show their progress and areas for improvement. For example, providing monthly reports on delayed discharges.

Learning, continuous improvement and innovation

- The CAMHS ward shared and learned good practice with other Priory CAMHS wards. It was part of the wider

Priory CAMHS network.Priory CAMHS ward managers met quarterly to share learning. The Prior CAMHS service line lead sent a weekly CAMHS bulletin to the ward to continue shared learning specific to CAMHS.

- The ward had participated in a nationally accredited quality improvement programme, for CAMHS inpatient services. The purpose of this accreditation is to improve the care for inpatient mental health wards in the United Kingdom and work towards a purposeful admission within the context of a safe and therapeutic environment.
- The ward was involved in the new models of care pilot project in CAMHS. This was led by two London NHS trusts. The pilot will trial new ways of managing the pathway to tier 4 inpatient admissions for children and young people, and will aim to improve. For example, it aims to prevent avoidable psychiatric hospital admissions and reduce length of staff for young people admitted to tier 4 beds.

Requires improvement

Specialist eating disorder services

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

Are specialist eating disorder services safe?

Requires improvement

Safe and clean environment

Safety of the ward layout

- Staff carried out regular risk assessments of the care environment to ensure that patients were safe. Where concerns were identified, these were escalated to the maintenance team, to action. For example, we saw maintenance staff repairing a door to the ward that staff had reported.
- The layout of both wards did not allow for clear lines of sight for observing patients. There were numerous blind spots on both Priory Court and Upper Court. Staff mitigated this risk through carrying out regular safety checks, observations and engagement with patients. There was a designated observation nurse. The hospital had a camera system installed in areas of heightened risk in communal and bedroom areas. The cameras were monitored by an external body and alerted staff on a hand-held device when ligature anchor points were tampered with. At the time of the inspection none of the ligature points in the communal areas such as bathroom door handles had been identified as requiring activation. All activations were based on level of risk.
- There were CCTV cameras in the safer rooms on the wards. Safer rooms were rooms for patients at increased risk of self-harm. There were no ligature anchor points in these rooms, such as door handles, cupboard doors, TVs or lamps with trailing wires.
- Both wards had a ligature point (fittings to which patient's intent on self-injury might tie something to harm themselves) risk assessments and management plans in place to reduce risks. The risk assessment on Priory Court was in the process of being updated following the completion of refurbishment on the ward. Staff we spoke with were able to identify and describe the current ligature risks and the measures in place to manage these.
- All bedroom doors on Priory Court were fitted with anti-barricade doors. Anti-barricade doors lock so if a patient puts himself or herself or an object against the door to prevent entry, staff can open the doors outwards and ensure safety is maintained. Staff reported that they had undertaken training on how to safely open the doors.
- Ligature cutters were available and visible in each nursing office.
- Priory Court was a mixed gender ward. Upper Court only accommodated female patients.
- Nurse call alarm systems were in place in individual bedrooms, bathrooms, toilets and communal areas.
- Each patient had a personal emergency evacuation plan (PEEP) in the event of a fire. This indicated whether or not the patient required assistance to evacuate in the event of a fire. Reception staff were updated daily on the PEEPs for both wards.

Maintenance, cleanliness and infection control

- In August 2017, we found that that the nasogastric feeding rooms on Priory Court and Upper Court did not provide safe and clean environments. On Priory Court, the nasogastric feeding room had no hand soap, and

the seating and trolley for nasogastric feeding were visibly unclean. The sharps bin was not signed or dated. On Upper Court, the nasogastric feeds and equipment were stored around a toilet in the en-suite bathroom. There was no adequate preparation space for staff to prepare the nasogastric feeds. At the November 2017 inspection, we found that improvements had been made. On Priory Court and Upper Court there were dedicated feeding rooms with a sink and handwashing soap for staff. There was adequate preparation space for staff to prepare the nasogastric feeds. The environment, including the seat and trolley in each feeding room was visibly clean. Staff completed a daily cleaning checklist of each room. We observed an episode of nasogastric feeding on both wards and saw that staff followed infection control procedures before, during and after the feed.

- All ward areas were visibly clean, had good furnishings, were well-maintained and the décor was in good order. Domestic staff completed cleaning schedules each day which demonstrated that the ward areas were cleaned regularly.
- Staff followed infection control procedures to keep patients safe. Disposable gloves, aprons and liquid gel were available.

Clinic room and equipment

- In August 2017, we found that we found that staff lacked an understanding of how to use and calibrate the blood glucose monitoring machines on a daily basis. At the November 2017 inspection, improvements had been made. Staff had undertaken physical health monitoring training which included the calibration of blood glucose monitoring machines. Records demonstrated that daily calibration checks were taking place.
- Each ward had a fully equipped clinic room. In August 2017, we found a number of out of date items in the emergency bags on Priory and Upper Court. At the November 2017 inspection, improvements had been made on both wards. Emergency medicines and equipment were being checked regularly on Priory Court and Upper Court. Staff checked emergency medicines regularly to ensure they were within date and fit for use on Priory Court and Upper Court.
- Each clinic room had a range of equipment. This included blood pressure monitors, electrocardiogram machine and weighing scales. However, on Priory Court we found that the ear thermometer and the blood glucose tester both had the battery cover broken off and the batteries showing. The provider confirmed that both items had been replaced following the inspection. We also found that the blood glucose testing liquid in both clinic rooms did not have the date of opening recorded. This was addressed at the time of the inspection and new bottles opened and dated.

Safe staffing

Nursing staff

- Ward staffing levels were set according to the number of patients admitted to a ward. The wards used a staffing ladder to adjust the number of staff on duty according to the number of patients on the ward at the time, their assessed needs and the resources required to meet this.
- Priory Court had an establishment of 12.5 qualified nursing posts and 17 healthcare assistant posts. There were four vacancies for qualified nurses and no vacancies for healthcare assistants. Upper Court had an establishment of 8.5 qualified nursing posts and 11.5 healthcare assistant posts. There were no vacancies for nursing or healthcare assistant posts. The managers reported that there was an active recruitment programme in place to recruit to the vacant nursing positions.
- On Priory Court, there were three nurses on duty. One for each floor and a floating nurse. Staff on both wards reported that ward round days were difficult as the nurse would be attending the meeting.
- Any staff shortages were responded to appropriately. To ensure continuity of care for patients, staff that were familiar with the ward were booked to work where possible. On Priory Court from 1 August 2017 to 31 October 2017, 1548 shifts filled by staff , Of the 1548 shifts, agency staff covered 451 shifts (29%). On Upper Court from 1 August 2017 to 31 October 2017, shifts covered by staff was 937, agency staff covered 111 shifts (12%).The manager for the ward reported that this had been due to the high acuity of patients on the ward.
- The manager on Priory Court reported that they were offering three month contracts to agency staff so that patients received continuity in care.

- The wards were not always able to find bank or agency staff to fill provide cover for vacant staffing positions or for the absence of staff. The provider reported that from 1 August 2017 to 31 October 2017 there were 20 shifts which were not filled by bank or agency staff where there was sickness, absence or vacancies.
- All patients reported concerns regarding the high use of agency staff, many of which were unfamiliar with the wards and eating disorders. For example, staff reported an incident where a young person had purged following their meal because the agency member of staff had unlocked the toilet door. On Upper Court, a patient reported that there were occasional delays in them receiving their nasogastric feed on time.
- Managers had flexibility to adjust staffing levels to meet changes in clinical need such as levels of observation and escort duties.
- New agency and bank staff undertook an induction to the ward, which provided them with essential information for their shift. This included information on health and safety procedures, observation policy and safeguarding.
- We observed that both unqualified and qualified staff were available in the communal areas to attend to patients. Patients were attended to promptly when they required assistance or support.
- Patients reported that there were usually enough staff to facilitate leave and activities. Patients received regular one-to-one time with their named nurse or co-worker. Care records we viewed demonstrated this.
- Both managers reported that there were no instances of the cancellation of patient activities or leave due to a shortage of staff.
- There were enough staff on duty to carry out physical interventions safely. Physical intervention training included how to restrain a person with a low body weight safely and during nasogastric feeding.
- Staff we spoke with had a good understanding of the use of preventative strategies and that physical intervention was a last resort.

Medical staff

- There was adequate medical cover day and night. A ward doctor was available on both wards. The ward doctor from Upper Court was providing cover for ward doctor duties on Priory Court as their doctor was on leave. Duty doctors were available on site out of hours and at the weekend. Duty doctors had access to the consultant psychiatrist on call if they required expert advice to deal with medical and psychiatric emergencies.

Mandatory training

- Staff completed mandatory training so that they had the appropriate skills and knowledge to carry out their roles and responsibilities safely. Managers kept an up to date record for each staff member showing what courses staff had done and when training was due for renewal. Mandatory training covered a range of subjects including health and safety, information governance, safeguarding, moving and handling and infection control. The compliance rate on Priory Court for most areas averaged over 75%. However, on Upper Court training in Prevention Management of Violence and Aggression (PMVA) was at 56%, and PMVA breakaway was at 68%. These areas had been identified by the provider and were being followed up by the individual ward managers.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We reviewed six patient records and found that all patients had a comprehensive risk assessment which was up to date. Individual risks to patients were assessed by the multidisciplinary team and updated following incidents.
- Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies and monitoring or changes in behaviour. Assessments included the patients mental and physical health needs such as Waterlow pressure ulcer risk assessment, hypothermia, body mapping and falls assessments.

Management of patient risk

- In August 2017, we found that on Upper Court and Priory Court staff had not always accurately recorded patients' physical health observations as prescribed or escalated physical health observations when they should have been. On both wards, staff recorded physical health checks using the management of really

sick patients with anorexia nervosa (MARSIPAN) score sheet that was specifically designed to calculate the physical health risks to patients with eating disorders. At the November 2017 inspection, we found that improvements had been made. We reviewed six records and saw that scores had been accurately recorded and doctors were notified when deterioration in physical health was indicated. The ward doctor reviewed all MARSI-MEWS daily. However, on Upper Court for one patient whilst the nursing staff called the doctor, who confirmed they had attended and reviewed the patient no record of the review had been made. This meant that there was a risk that there was no clear audit trail about the care and treatment of the patient.

- Staff identified and responded to changing patient risks. For example, the level of physical health monitoring increased by staff carrying out daily ECG's for a patient whose physical health was deteriorating. For another patient, we saw that their mobility had been reassessed and they were required to use a wheelchair.
- Staff had developed effective risk management plans in response to identified risk such as refeeding syndrome and the risk of self-harm. Individual risks were discussed in multi-disciplinary meetings, individual reviews, handovers and best interest meetings.
- Staff carried out various levels of patient observation on the ward to ensure effective risk management. The service had policies and procedures for searching patients and for the observation of patients.
- Blanket restrictions were in place on both wards and were in accordance with the therapeutic model to manage eating disordered patients. On Priory Court, there were age appropriate restrictions which included the use of a mobile telephone and bed times for patients. Where patients had been assessed as having restricted access to their bedrooms, this was discussed within the MDT and clearly recorded in the care plan. There were some other restrictions in place in relation to accessing food and drinks due to the impact on patient's health and recovery process. These restrictions were recorded and part of the dietician's nutritional assessment and patient risk assessment.
- The hospital had a smoke free policy. Patients were supported with smoking cessation where required. Staff explained the policy to patients on admission and it was outlined in their ward handbooks. However, children and young people were not permitted to smoke, in line with NHS England policy.
- Information was displayed on both wards informing informal patients of their rights to leave the ward.

Use of restrictive interventions

- In August 2017, we found that the hospital had failed to take sufficient steps to ensure that all staff completed physical health assessments and monitored vital signs for all patients following rapid tranquilisation. At the November 2017 inspection, we found that improvements had been made.A new rapid tranquilisation tracker system had been implemented. This was being used by staff to oversee and monitor the amount of rapid tranquilisation and post physical health observation monitoring.
- We looked at six rapid tranquilisation observation charts and the corresponding rapid tranquilisation tracker. However, on Priory court we found two incidents where staff had not carried out post physical health checks in line with their policy. On one record staff had not commenced the physical health observations until 75 minutes after rapid tranquilisation was administered. For another patient physical health observations were not carried out until 3 hours after rapid tranquilisation had been administered. There were no reasons recorded as to why these were completed late.
- In the three months up to 25 September 2017, there had been 45 incidents of restraint on eight different patients. None of the incidences used prone restraint. On Priory Court 43 incidents were recorded, 32 of these incidents related to three patients with one patient having seventeen incidents of restraint. Most of the incidents related to patients who required nasogastric feeding and prevention of self-harm.
- Staff confirmed that they used physical intervention as a last resort and used this only after preventative strategies such as de-escalation had failed.

Safeguarding

- Staff were trained in safeguarding adults and children, knew how to make a safeguarding alert, and did that when appropriate. For example, Priory Court had raised

a safeguarding alert in response to a complaint they had received. The hospital had a safeguarding lead who worked in partnership with other agencies including social services, children's safeguarding and the police.

- Staff described how they protected patients from harassment and discrimination. For example, staff discussed bullying and harassment at the weekly community meeting. The MDT discussed the possibility of individual patients being vulnerable to exploitation or violence. Staff took action to minimise these potential risks and ensured that there was a member of staff in the communal areas to support patients.
- Staff followed safe procedures for children and adults visiting the ward. Visiting arrangements were discussed within the MDT to ensure the appropriateness of the visit.

Staff access to essential information

- Staff used a combination of electronic and paper records. The electronic record was the main record that staff used. Patient information was accessible. In August 2017, we recommended that personal log-in details of permanent were not shared with agency and or student staff. At this inspection we found that improvements had been made. There was a list of temporary log-ins that agency and student staff could be provided with. Information reminding staff not to share their log-in was displayed in the nursing offices.
- Staff used paper records to record readings from physical observations such as blood pressure, pulse, temperature, food and fluid charts.
- There were no concerns reported with accessing information and staff knew where patient information was held. Staff were able to access information when patients moved between teams. For example, referral information and CPA documentation was available on the electronic system.

Medicines management

- Medicines were seen to be stored in a safe manner and the administration of these was recorded. People were supplied leave medicines in a safe manner and appropriate records were made of these. For medicines prescribed to be given when required there was insufficient information available to staff on how to make their decision on the dose to be administered and records made after administration did not document how the decision had been made. A pharmacist visited each ward weekly.
- Staff reviewed the effects of medicine on patient's physical health regularly in line with the National Institute for Health and Care Excellence NICE) guidance.

Track record on safety

- Between 1 January 2017 and 31 October 2017, specialist eating disorder services reported 22 serious incidents. These included incidents of self-harm, absconsing and physical health deterioration.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents to report and reported all incidents on the electronic incident reporting system in line with hospital procedures. Staff had a good understanding of what type of incidents should be reported. For example, all self-harm and incidents of aggression were reported on both wards.
- Incidents were reviewed by each ward manager and where appropriate investigated. Staff updated patients' risk assessment and progress notes, following an incident.
- Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. For example, for one patient staff had an offered an apology when the patient had been provided with a diet that did not meet their specific preference.
- Staff received feedback from investigations so that learning and improvements could be made. Information was shared at team meetings, handovers, staff emails, incident briefings, daily flash meetings and the weekly learning outcome group.
- Changes were made to the service following investigations of incidents. For example, on Priory Court changes had been made to the way parcels were received and opened by patients following a self-harm incident. On Upper Court changes had been made to access the nursing office through the use of a fob following an incident where a patient had accessed the nursing office

Requires improvement

Specialist eating disorder services

- Staff were offered de-briefing meetings and support following incidents. This was through de-briefing after the incident, reflective practice groups and team meetings.
- Following the receipt of a coroner's report relating to a death at the hospital in 2015, the provider had increased the frequency of ligature and blind spot risk assessments, commenced weekly quality walk-arounds, and introduced observational competency checklists for new staff and agency workers.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- All admissions to Priory Court and Upper Court were planned. We reviewed six care records and all patients had detailed and timely assessments of their current mental state, previous history, physical healthcare needs and risk behaviours. There was a holistic approach to assessing, planning and delivering care and treatment to patients within a multi-disciplinary team collaborative approach to care and treatment.
- Comprehensive physical healthcare assessments were carried out in a timely manner after admission. Each patient had a thorough recorded medical assessment on admission. Both wards used a physical healthcare algorithm on admission so that any physical healthcare needs of the patient could be promptly identified.
- Physical healthcare records showed that there was on-going monitoring of health conditions and healthcare investigations to ensure patients were cared for safely. This included close and regular monitoring of bloods, heart rate, pulse, urine, temperature, weight monitoring and electrocardiogram (ECG). An ECG checks the hearts rhythm and electric activity and is important to ensure patients receive the right treatment and medicine. Where appropriate, patients had bone density scans.
- Patients had care plans to address and support their individual identified needs. Care plans were personalised, holistic, recovery-oriented and regularly reviewed. Patients were involved in the planning and review of their care. Care plans reflected the views of patients and their relatives about their care and treatment. For example, we saw that needs identified by the patient had been recorded and discussed. For another patient, we saw that the doctor had discussed the risks of mobilisation when physical health risks were high. However, we found that three care plans were not always updated when there had been a change in care or presentation. For example, the risk assessment for two patients had been updated to reflect the change in observation levels however the corresponding care plan had not. Team meeting minutes viewed on Upper Court showed that this shortfall had been identified through the audit process and was being addressed through team meetings and individual supervision.

Best practice in treatment and care

- The staff team planned and delivered care and treatment interventions based on best practice and evidence based guidance. The staff team followed guidance based on the Management of really sick patients with anorexia nervosa (MARSIPAN) and Junior MARSIPAN guidelines. These guidelines provide guidance on the clinical management and care of really unwell patients with anorexia nervosa risk assessing, treatments and re-feeding management. This tool is approved by the Royal College of Psychiatrists and the Royal College of Physicians and staff used this to carry out safe refeeding, risk management and monitoring.
- When patients were prescribed medicines, doctors considered best practice guidance from the National Institute of Clinical Excellence (NICE).
- Psychological therapies, as recommended by NICE, were available to patients including psychotherapy, family therapy, dialectical behavioural therapy, radically open dialectical behaviour therapy and cognitive behavioural therapy. Group and individual therapy sessions were available to support behaviour change around food. The MDT reviewed the therapies offered to each patient to ensure that they were effective and appropriate for their needs.
- Staff ensured that patients had access to physical healthcare, including specialists when needed. Each ward was supported by a physical health lead nurse,

who provided support and advice to the nursing teams. Staff referred patients to specialists whenever necessary and worked closely with the acute hospitals. This included referrals to cardiologists, dentists and opticians.

- The service employed two part-time dieticians who worked within the multidisciplinary team. The dieticians carried out comprehensive nutritional and hydration assessments to ensure that nutritional restoration was carried out safely including nasogastric feeding. Individualised eating plans were prescribed and refeeding risks comprehensively considered. A range of recovery focused groups were offered which involved supermarket shopping and food preparation were also offered. Some patients on Priory Court participated in "Come dine with me" sessions where take away food was ordered onto the unit.
- Staff supported patients to live healthier lives by providing patients with smoking cessation advice and products. On Priory Court, staff provided sexual health advice and education to young people. The dietician co-facilitated the weekly carers group and provided information on food nutrition, refeeding syndrome and leave planning.
- The wards used a range of outcome measure tools to measure patients' progress, including Health of the Nation Outcome Scale for adults (HoNOS) and children (HoNOSCA), Eating Disorder Questionnaire (EDQ) and the Children's Global Assessment Scale to measure the mental health of children and young people.
- Staff used technology effectively to support patients. For example, staff were able to access the internet to look at relevant guidance. However, we found that medical staff were unable to access blood test results promptly and results took 48 hours to be received. The service used an external pathology service and an electronic system for sharing results was not yet available. We raised this during our inspection and action was taken by the provider which included the pathology service emailing the hospital twice daily, critical results would be telephoned through and the registered medical officer added to the out of hours email distribution list. The service had also agreed for bloods to be taken and collected earlier for a quicker turn around and for each ward to have a bloods log book.
- Staff completed a number of clinical audits in the service, including care plan documentation, physical health observations, medicines management and health and safety.

Skilled staff to deliver care

- Both wards had multi-disciplinary teams (MDT) to meet the needs of the patients. The teams included nurses, health care assistants, psychologists, psychotherapists, family therapists, occupational therapists, activity co-ordinators, dietitians, consultant psychiatrists and ward doctors. On Priory Court, teachers at the school attached to the ward were also part of the MDT.
- Staff working in the service were experienced and qualified to provide care and treatment.
- All staff, including bank and agency staff, received a thorough induction into the service. The care certificate standards were used as a benchmark for health care assistants. These standards set out the skills and knowledge required by staff. Staff also received specific induction training on eating disorders which included observation and meal management.
- Staff had regular and appropriate management and clinical supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development)and an annual appraisal of their work performance.
- Staff were supported with appropriate training and professional development to develop their skills and knowledge. Staff had access to specialist training relevant to the patient group they were caring for. Nursing staff were provided with training on eating disorders and nasogastric feeding. Several staff confirmed that they had not completed all six modules of the eating disorders course. We raised this with the provider who confirmed that all staff had been booked to complete the training by the end of November 2017. Preceptorship training was offered to newly qualified nurses. This helped ensure that they had the skills needed to complete their role and they were well supported. Nursing staff were supported with their revalidation.
- Staff had access to regular team meetings and reflective group supervision to discuss patient cases.

- Policies and procedures were available to deal with staff performance effectively. The human resources department provided support to ward managers.

Multi-disciplinary and inter-agency team work

- Staff held regular and effective multidisciplinary meetings on each ward to collaboratively manage referrals, risks, treatment and appropriate care pathways options. All consultants held weekly multidisciplinary meetings. During the inspection we attended one meeting on Priory Court. Individual patient needs, risks, goal setting and discharge planning were discussed. Each patient was discussed at length and invited to attend their part of the meeting.
- Nursing handovers included all relevant information regarding patients, including the patients' risk rating and observation levels.
- Staff in the service maintained effective relationships with other services and organisations. For example, we saw that staff worked with the community CAMHS team, general practitioners, commissioners and other eating disorder units.

Adherence to the MHA and the MHA Code of Practice

- Staff undertook training on the Mental Health Act as part of their mandatory training. On Upper Court the compliance rate was 89% and on Priory Court 93%.
- There was a Mental Health Act administrator based onsite. Staff knew how to contact them for advice where necessary.
- Staff discussed patients' mental capacity and consent to treatment at each ward round. These discussions were comprehensively recorded.
- Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted. Detention papers were stored appropriately. Staff requested an opinion from a second opinion appointed doctor when necessary.
- We carried out a Mental Health Act visit to Upper Court in February 2016. At this visit we found that patients had poor access to IMHA services and that there was a lack of review of capacity assessments.
- We carried out a MHA visit to Priory Court in September 2016. At this visit we found that patients did not have their MHA rights explained, AMHP reports were not available and there was a lack of authorisation for treatment.
- During this inspection, we found evidence that these issues had been addressed. There was now an established IMHA services available to all detained patients provided by Rethink. The wards displayed information regarding the MHA, including information concerning the independent mental health advocate (IMHA).
- There was a regular audits in place to ensure that initial assessments of capacity to consent to treatment were completed and kept under review.
- We found that staff explained patients' rights under the Mental Health Act to them at admission and at regular intervals during the period of their detention.
- There was some on-going difficulty in obtaining AMHP reports where the patient had first been detained elsewhere.
- The wards displayed a notice to tell adult informal patients that they could leave the ward freely.

Good practice in applying the MCA

- Staff received training in the Mental Capacity Act 2005 (MCA). On Upper Court the compliance rate was 89% and on Priory Court 85%.
- Staff understood the principles of the MCA (which is applicable to people over 16) and supported patients to make decisions. Staff confirmed that capacity was assumed unless proven otherwise. For example, we saw that where patients had been admitted informally a comprehensive capacity assessment had been undertaken and the records detailed that they had consented to admission, treatment and some of the restrictions applicable to the service.
- We saw detailed records relating to the assessment and understanding of capacity across the service where decision specific assessments had been made and the best interests of the individual considered.
- Staff on Priory Court had an understanding of Gillick competence, which is where a person is assessed and

deemed to have the competence to make decision about their own care, without the need for parental consent. Competency of patients was clearly assessed and recorded.

Are specialist eating disorder services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- We received mixed feedback from patients about the quality of care that patients received from staff on the wards. On Priory Court, we spoke to five patients. Three patients said that they felt staff were not always caring and did not support them. They felt that staff did not always understand their needs.
- On Upper Court, five out of the six patients we spoke to said staff were supportive and easy to get along with. All staff went out of the way to help them and made time to support them and promote their interests.
- We observed staff interacting with patients in a thoughtful and respectful way. We observed a community meeting and a ward round on Priory Court. Staff showed patients emotional support and advice. We saw staff in the ward round have discreet and respectful discussions about a patient and how they were progressing. Observations of the general environment throughout the inspection showed staff treating patients with compassion and respect on both wards.
- Staff supported patients to understand and manage their care, treatment or condition. Patients had access to welcome information, including information about rights and rights of informal patients. Ward noticeboards gave patients information about therapies and activities available on the wards. For example, staff supported patients post meals each day to provide support and management of their eating disorder. Information packs were also provided for patients, parents and carers.
- Staff directed patients to other services when appropriate and, if required, supported them to access those services. For example, staff had strong links with the local acute hospital to support patients with their physical health needs. If a patient became unwell then staff supported them to the hospital and worked with the general hospital in how best to support them. This meant staff were aware of the need to work with other services to support patients appropriately.
- Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. On Upper Court, matters of privacy and dignity were brought to the community meeting for patients to comment about how they would like staff to conduct certain personal care support. In a ward round that we observed on Priory Court, staff spoke about patients with compassion, knowledge and understanding of their personal needs. For example, staff discussed strategies that would work for the patient.
- Staff maintained the confidentiality of information about patients. During the inspection staff always sought the consent of the patient for any observations or discussions carried out with the patient whilst we were there.

Involvement in care

Involvement of patients

- When patients were first admitted to the service staff informed and orientated them to the ward. Patients received a welcome pack upon admission. This contained information on the service, treatment and care provided and essential information about the ward, including meal times, MDT, visiting arrangements and complaints procedure.
- We looked at nine patient care records across both wards. Each record showed evidence of patient involvement, including whether the patient wanted a copy of their care plan for their own use. We observed patients participating in their ward rounds on Priory Court. Patients discussed their risk assessment, leave and progress with the multi-disciplinary team (MDT). Patients could feedback about their care to the MDT through other forms of communication, like in writing, if they felt unable to speak up in person.
- Staff involved patients in decisions about the service. For example, on Priory Court, patient's fed back about how they would like the new nasogastric feeding room to be decorated. Staff facilitated this to provide a

positive atmosphere. On Upper Court, patients decided on the name for the new nasogastric feeding room. Patients on both wards also came up with 'Welcome to EDU' displayed on the walls. It gave a series of tips and useful information for new staff and agency staff to take on board so they can provide better care to patients. This included etiquette during meals, boundaries, helpful language to use and difficult discussions staff should avoid.

- Patients could feedback on the quality of the service via weekly meetings. We looked at the community meeting minutes on both Priory court and Upper Court. These were summarised as a 'you said, we did' document, the most recent of which was displayed in the ward areas. Feedback included issues around agency staff and having more ward trips.
- Patients had access to local advocacy services to support them to speak up and have their voice heard. Advocates attended the ward regularly and information was provided on the wards. On Priory Court, we observed the advocate present on the ward.

Involvement of families and carers

- Staff informed and involved families and carers appropriately and provided them with support when needed. As part of some patients treatment plans, families and carers were invited to eat meals with their relatives on both wards. On Priory Court, the dietician worked with parents on managing periods of home leave so that they could support their family members eating safely. On Priory Court, parents and carers were invited to ward rounds.This meant that families could support their relatives in their recovery and treatment.
- Staff enabled families and carers to give feedback on the service they received through ward rounds, individual meetings and the weekly carer support groups held on each ward. This meant that families could discuss how they were feeling and where they needed support to manage their relative's treatment and recovery. On Priory Court, parents had contributed to the development of the parents/carers handbook.
- The psychologist on Priory Court provided carer skills training based on the Maudsley communication styles model for supporting parents with communication and parenting styles. The Maudsley approach enabled parents to play an active and positive role in helping to restore their child's weight.

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

(for example, to feedback?)

Requires improvement

Access and discharge

Bed Management

- The service accepted referrals from community services and other inpatient services from across the country. Most patients were from London or South East England. All admissions were planned. Ward managers screened referrals and discussed any concerns they had within the wider multidisciplinary team to ensure the service was suitable to meet the patient's needs.
- Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. This meant that the patient's allocated room remained vacant whilst they were on leave and until their return to the ward. On Priory Court, patients who were due to turn 18 were supported to transfer to Upper Court. Staff worked closely with the young person and family to facilitate this safely.
- When patients were moved or discharged from a ward, staff told us this happened at an appropriate time during the day.
- The inspection team were not made aware of any instances where a patient required a bed in a psychiatric intensive care unit.

Discharges and transfers of care

- There were no delayed discharges on Priory Court. Upper Court had one reported delayed discharge. This was due to complexities with the care package provision.
- Discharges were planned through the Care Programme Approach framework Where patients were ready for

discharge, care and treatment records evidenced good liaison with care co-ordinators and other services. For example, on Priory Court staff worked with a local community eating disorder service in preparation for a patients discharge. Care records detailed discharge planning where appropriate. The staff team worked collaboratively with local hospitals, community mental health teams, eating disorder teams and other agencies to support the transition from an inpatient stay through to discharge.

- Staff supported patients during referrals and transfers between services. For example, staff described on Priory Court how they had supported a patient who required admission to an acute medical ward for care and treatment. This included ensuring that a member of staff from the ward stayed with the patient.

Facilities that promote comfort, dignity and privacy

- All bedrooms were single. Patients could personalise their bedrooms with photographs and posters if they wished.
- All patients could lock items in their bedrooms, though patients needed to ask staff if they wanted their bedroom door to be locked when they were out of the ward or not using it. Patients told us they felt their possessions were safe. Contraband items were held in lockers elsewhere on the wards, and were given back to patients on discharge.
- In August 2017, we found that there was no de-escalation/self-soothe room available and no privacy for patients who were distressed on Priory Court. The action plan submitted by the provider detailed that the ward was to have a quiet/ de-escalation room on the ward by the end of October 2017. At this inspection, we found that work was on-going and a revised completion date for December 2017 had been set due to building contractor delays.
- In August 2017, we found that the nasogastric feeding rooms on both wards were decorated in a way that was not therapeutic to patients. They were clinical and sparse. At this inspection, we found that improvements had been made. On Priory Court patients had suggested that the rooms be decorated with inspirational quotes. The interior design team aimed to complete this by December 2017.
- In August 2017, we found that the dining room on Upper Court was too small and did not provide a positive therapeutic environment for patients. At this inspection we found that work was on-going and plans were in place to have a larger dining room which could accommodate all patients by August 2018. Patients who were able to do so accessed the restaurant on the ground floor through Garden Wing ward.
- Improvements to the ward environments better supported the care and treatment of patients. On both wards the lounge areas had been redecorated and new furniture provided. There were rooms available for patients to speak with a member of staff, their relatives, see visitors and advocate in private. Other rooms were available in the hospital when patients wanted to see visitors off the ward.
- Patients could make a phone call in private.
- Patients had access to outside space, which included the garden and hospital grounds. On both wards, walks in the grounds were facilitated by staff. Exercise plans were in place for patients where appropriate. For some patients, exercise was restricted due to a low body mass index and physical health risks. However, on Priory Court there were specific health and safety risk assessments, which included one for escorting young people on the grounds. However, it did not cover escorting young people in the hours of darkness. We observed staff escorting young patients around the grounds after dark and through the parking lot. There were not enough outdoor lights to ensure that staff and patients had their path illuminated throughout their walk. This meant that staff and patients may be at risk of trips or falls.
- All drinks and snacks required by the patient were assessed by the dietician and incorporated into individual meal plans which had been prepared in collaboration with individual patients so that nutritional restoration was safe. Additional fluids where prescribed where appropriate during periods of hot weather to reduce the risk of de-hydration. Patients confirmed that any specific dietary requirements were respected such as vegan food.

- Information packs detailed restrictions for parents and carers about bringing additional food onto the wards so that staff could correctly monitor patient's food and drink intake.
- Patients had access to group activities on the ward and at the therapy centre, which were facilitated by members of the MDT. Groups provided had a focus on education, recovery and rehabilitation.

Patients engagement with the wider community

- Where appropriate, staff ensured that patients had access to education and work opportunities. Young people who were well enough on Priory Court accessed education classes at the school on site. Each patient had an individual education plan and teachers made contact with schools and colleges that the young person attended prior to admission.
- Staff encouraged patients to develop and maintain relationships with people who mattered to them, both within the service and the wider community. Staff supported patients to maintain contact with their families and carers. Care records demonstrated that regular contact was maintained with family members and carers as agreed with the patient and MDT.

Meeting the needs of people who use the service

- Patients could access Priory Court by a lift from the ground floor to the lower and upper levels of the ward. However, Upper Court did not have a lift and did not admit patients with high mobility needs.
- The wards had a number of notice boards which displayed a range of information for patients and carers, including information about how to complain, safeguarding, eating disorders, carers support, local services and advocacy services.
- Ward managers confirmed that leaflets and information could be translated into different languages where required.
- The service could provide interpreters when required.
- Food to meet the dietary requirements of religious and ethnic groups was available. The dietician and staff worked closely with the catering team to ensure that people's individual preferences were met.
- Patients had access to appropriate religious and spiritual support. There was access to chaplaincy services at the hospital.

Listening to and learning from complaints

- From 1 January 2017 to 12 October 2017, the service had received five complaints. Three of these were on Upper Court and Two on Priory Court. One complaint was upheld, two were not upheld, one was partially upheld and one withdrawn. The provider investigated all complaints and provided a response to the complainant.
- Patients we spoke with knew how to complain and felt comfortable doing so. One patient said staff had been very compassionate and supportive when they wanted to make a complaint.
- Patients were aware of how to make a complaint or provide feedback about the ward they were staying on and felt comfortable doing so. Each ward held regular community meetings with patients where concerns, compliments and complaints could be raised. Minutes of the meetings were available for patients to refer to.
- Where patients complained or raised concerns, they received feedback. For example, on Upper Court we saw that patients had raised concerns about their bedrooms not being cleaned enough. This resulted in an increase in the frequency of rooms being cleaned. On Priory Court, patients reported concerns that bank and agency staff were not supportive at meal times. This had resulted in a more detailed handover now takes place at the start of shifts so that patients were better supported.
- Complaints were received, recorded and managed appropriately by staff. They were reviewed and monitored on a regular basis by the ward managers and senior managers to ensure that any themes and trends were identified and improvements made.
- Staff learnt from complaints, investigations and findings through their team meetings and learning outcomes group.

Are specialist eating disorder services well-led?

Requires improvement

Specialist eating disorder services

Good

Leadership

- Leaders had the skills, knowledge and experience to perform their roles. Each ward manager had support from a deputy ward manager to carry out their roles effectively. Ward managers also had support from senior management.
- Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. On Upper Court the ward manager had only been in post since July 2017 and was covering maternity leave. This meant that they were still getting to know the service.
- Leaders were visible in the service and approachable for patients and staff. Staff and patients we approached knew the service managers for both wards. They were visible on the wards on a regular basis.
- Leadership development opportunities were available, including opportunities for staff below team manager level. On Upper Court, the senior nurse covered the ward manager post for an interim period. Also, during the inspection, we heard how a nurse had been successfully recruited to a senior level nurse.

Vision and strategy

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. This was reflected in our discussions with staff on the wards. Staff and managers within the service consistently emphasised their desire to improve patient care.
- Staff did not always feel they were informed about changes to the service. For example, on Priory Court the move to split the ward and increase to upstairs had not been communicated until it happened. This resulted in a change to the way the ward was staffed across the two floors.
- Staff could explain how they were working to deliver high quality care within the budgets available. Upper Court staff described the doorbell not working to access the ward in a timely manner. A new door bell had not been fitted but staff were still able to carry out their roles, even though it consumed more time to do so.

Culture

- Staff felt respected, supported and valued by their managers. Staff felt positive and proud about working for the provider and their team. Staff on Upper Court had recently attended a team away day. This was to promote team building on the ward.
- Staff had an awareness of the whistleblowing process knew how to use it if they needed to. Staff told us that they felt able to raise concerns without fear of retribution. Staff spoke positively about being able to approach their ward manager if they needed to express concerns.
- Teams worked well together and where there were difficulties managers dealt with them appropriately. Managers dealt with poor staff performance in supervision and appraisals appropriately. Staff appraisals also included conversations about career development and how it could be supported. Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. Staff were supported to develop their skills and undertake training. For example, healthcare assistants were supported to undertake the care certificate. Specialist training in eating disorders was available for staff. This was a six month programme where staff had to commit to one day a month for a continuous six months.
- Both wards had minimal staff turnover in the last three months. From August to October 2017, two staff members had left Priory Court and one staff member had left employment on Upper Court.
- From August to October 2017 both wards had sporadic staff sickness absence levels compared to the hospital average. Upper court had high levels of sickness at 12% and 11% for August and September respectively. Priory Court had an 8% sickness rate for both September and October. Managers told us about some long term sickness, including sickness following assaults by patients. We found that reasonable adjustments were made for staff returning to work after injury, or requiring lighter duties due to ill health or pregnancy.

Requires improvement

Specialist eating disorder services

Governance

- There were regular team and management meetings with a clear agenda of what must be discussed. This ensured that essential information, such as learning from incidents, safeguarding and complaints, was shared and discussed. The ward managers attended weekly learning outcome group meetings. We looked at the minutes of these meetings for the previous month. Managers from other wards came together to discuss incidents and share learning from them. Safeguarding and serious incidents were also discussed. This meant managers from across the hospital monitored and improved the service together.
- Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. There were systems of governance processes in the hospital for ward managers to monitor and improve their wards. For example, the ward managers monitored the use of rapid tranquilisation on both wards to ensure that it was safely carried out. All incidents were recorded onto the electronic online system, which the ward managers monitored themselves.
- Senior management had oversight of the hospital's complaints. A complaints register monitored formal complaints across the wards. It included information regarding date complaint was raised, name of investigator, date the holding letter and final response was sent, and lessons learned.
- The ward managers kept their own spreadsheet to monitor and ensure staff supervision was taken place on a monthly basis. However, staff training on Upper Court was low in basic life support, prevention and management of violence and aggression and breakaway. The ward manager knew it was low but could not access the training system yet due to a delay in allowing access.This meant that the ward manager on Upper Court did not have a clear way to monitor staff training.
- The ward managers completed daily audits on the wards, including care plans, physical health checks and equipment and environment checks. Senior management took part in quality walk rounds with the patients on Priory and Upper Court. This included gathering feedback from patients about the quality of care and treatment they receive. Including feedback on their medication, staff attitudes, treatment programmes and the safety of the environment. The audits were sufficient to provide assurance and staff acted on the results when needed.
- Staff understood the arrangements for working in team internally and with external agencies, to meet the needs of the patients. The hospital safeguarding lead raised safeguarding concerns with the local authority (LA). They had close links with the LA to provide extra advice or assistance to safeguard vulnerable adults and children from abuse. On Priory Court patients attended the school on the hospital grounds. This provided close working relations and continuity of care for the patients.

Management of risk, issues and performance

- Staff maintained and had access to the risk register at ward and directorate level. Staff at ward level could escalate concerns when required.
- The provider had piloted and then arranged for the installation of surveillance cameras in communal areas and bedrooms on each of the acute ward. They had increased the safety specifications of 'safer rooms' and undertaken removal of some identified ligature points.
- The service had plans for emergencies, for example, adverse weather or a flu outbreak. The service had a business contingency plan in case of an emergency and both ward managers were aware of it. At the August 2017 inspection, the provider did not ensure that contingency plans were in place in the event of unexpected computer outage are made clear to all staff on the wards. At this inspection, this had improved. The provider placed posters at the nurse's station to explain what to do and the ward managers communicated this to all staff.
- The hospital had plans in place to refurbish Upper Court due to the nature of the ward environment. There were many blind spots, reduced through a blind spot audit and the dining room was off the ward.

Information management

- Staff were satisfied with the systems in place to collect data from wards, and had access to the equipment and IT needed to do their work. At the last inspection in August 2017 staff shared their personal log-in details with agency and/or student staff. At this inspection, the

provider had implemented guest log-ins for all agency and student staff to use. This meant that information was shared at different levels dependent on the log-in provided, reducing the risk of a data breach.

- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff used an online electronic system to record patient care and treatment plans, incidents and access policies.
- Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.
- Staff made notifications to external bodies as needed. Staff provided notifications on patients absent without leave, allegations of abuse and any incidents involving the police to the Care Quality Commission (CQC) as required.

Engagement

- Staff had access to up-to-date information about the work of the hospital, for example, through the intranet, bulletins and newsletters. Patients and carers could receive recent information about the hospital through newsletters and from staff at community meetings.
- Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients fed back on the service through the community meetings and carers could also do this through the weekly support groups held.
- Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. Patients took part in the quality walk round by the senior management by providing feedback about the service. This feedback was passed onto staff to inform improvements. Staff completed staff surveys (morale-o-meter) to feedback on the quality of support they received from management. The results were fed back via bulletins.
- Patients and carers were involved in decision-making about changes to the service. Staff told us that hospital's senior leadership team where open to engagement with patients and relatives when requested.
- Senior management engaged with external stakeholders, such as commissioners. Ward managers were expected to provide reports to the commissioners to show their progress and areas for improvement.

Learning, continuous improvement and innovation

- Upper Court had recently been accredited by the Quality Network for Eating Disorders.
- Priory Court was part of a multi-centred research projects on Cognitive Behaviour Therapy in eating disorders (CBTE) verses radically open dialectical behaviour therapy (RO-DBT) as part of the Maudsley research programme.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- The hospital carried out weekly fire drills and completed annual fire risk assessments. Fire wardens were allocated on every shift. Fire wardens had responsibility to ensure the ward was evacuated in the event of a fire.
- Domestic staff cleaned bedrooms, communal areas and the clinic room regularly. Nursing staff recorded when clinical equipment was cleaned.
- The ward layout did not allow staff to have clear lines of sight throughout the ward. The ward had two main corridors with multiple adjoining bedrooms and hidden corners. The ward treated two separate patient groups: one group undergoing the addiction therapy programme and the other were undergoing the general therapy programme. Two separate lounges were provided for patients. A member of staff was allocated to observe the female corridor. Staff carried out regular observations on both corridors. All areas identified as having poor lines of sight were monitored by a camera system, which was monitored by an external company. There was also an observation nurse and a relational security nurse observing the area.
- The ward did not have its own garden or restaurant. Patients accessed the communal garden and restaurant by walking through a ward that treated acutely unwell patients. The provider recognised that this was not ideal, and the hospital had plans to address this issue during building works that were due to commence in 2018.
- Despite the ward completing a detailed ligature risk assessment in October 2017 that demonstrated how potential ligature anchor points were managed, we found that in two separate corridors there were ligature anchor points such as door handles and door closers that were not being managed safely. A ligature anchor point is an environmental feature or structure, which patients may use to fix a ligature with the intention of harming themselves. The ligature audit stated that these points were low risk and managed by 'high footfall' or by closed circuit television system (CCTV) that monitored high risk areas such as in patient bedrooms and communal areas. Patients consented to CCTV in their bedrooms. An external company would be alerted when ligature anchor points were touched monitored the CCTV. However, during our inspection on 9 November 2017 we observed that the stairwell that led up to the therapies department and the area outside of the clinical room was not closely monitored. These areas were quiet for periods whilst patients were in therapy sessions and the ligature anchor points were not linked to the CCTV system. This issue was escalated to the ward manager who reported that issues would be addressed by the maintenance team. The ward had not ensured that all ligature points had been mitigated safely or replaced with anti-ligature. During our follow up inspection on 21 November 2017, door handles had been changed. However, the door closers had not yet been addressed.
- The ward had four 'safer' bedrooms located near the nursing office, which meant the rooms had reduced ligature anchor points. These bedrooms were allocated to patients who were deemed to be at high risk of harm to themselves.
- The ward had a clinical room and a full range of equipment to support patients undergoing detoxification. The equipment was checked weekly. Between October and November 2017, staff recorded two abnormal results which they did not escalate this to

the nurse in charge. The abnormal result could have meant that the machine was not working correctly, resulting in inaccurate readings, which might have put patients at risk.

- The ward had emergency medicines and equipment available including oxygen and a defibrillator. Staff kept a checklist of the items that were contained in the emergency equipment bag. However, some items in the emergency bag were not recorded on the emergency bag checklist. For example, suction tubes and the manual suction tools were not included. This increased the risk of staff not checking that these items were in the bag at all times.
- The ward followed same gender accommodation guidance by ensuring that the male and female bedrooms were located on two separate corridors. All bedrooms had their own en-suite bathroom.
- Staff and patients had easy access to panic alarms. Staff accessed panic alarms in corridors and the nursing office. Patients had individual panic alarms in their bedrooms.

Safe staffing

- The wards current staffing establishment was nine qualified nurses and 10 HCAs. At the time of the inspection, the ward did not have any vacancies.
- In the past three months, a high number of agency staff covered vacant shifts. Agency staff covered 47% of day shifts. Agency and bank staff covered 95% of night shifts.The high use of bank and agency staff was attributed to two members of staff off on long-term sick leave and one member was on leave. Staff told us that they felt the ward managed this well.
- The majority of shifts were adequately staffed.However, on one occasion, the provider had not been able to fill a shift with an agency or bank member of staff.
- Since January 2017, the staff sickness rate had been 11%. This had been higher than usual because two members of staff had been off on long-term sick leave.
- Since January 2017, the ward had a low turnover rate of 3%.
- Ward staffing levels were determined by a 'staffing ladder' tool dependent on the number of patients on the ward. For example, the staffing establishment for a day and night shift that included less than 15 patients would require two qualified nurses and one HCA. A day shift that included more than 15 patients would require an additional HCA. During the inspection, we found that the ward was staffed according to the staffing ladder on most occasions.
- Bank and agency staff were used to cover leave and sickness. We saw that regular bank staff were used to ensure there was a continuity of care. All agency and bank staff were orientated to the ward and completed an induction checklist which included a tour of the ward, reviewing relevant policies and familiarising themselves with the patient group. Agency staff mostly worked with a permanent member of staff to ensure continuity for the patients. The hospital also had one floating nurse and a night coordinator available to support staff when required. The ward manager told us that agency and bank staff were offered supervision by HR.
- The hospital ensured that staff had completed full recruitment checks. We reviewed five employment records and found that staff had undergone criminal background checks. Nurses were appropriately qualified to carry out their role.
- A member of the nursing team was based in the main corridor of the ward at all times. This was to ensure patient safety. Staff carried out patient observations based on the needs and risk of the individual.
- On every shift, a designated bleep holder would respond to any clinical emergencies between the wards. The ward had a junior doctor who worked on the ward during office hours. Out of office hours, an agency doctor was available on-call in the evenings and weekends. The out of hour's doctor was employed by an agency.
- Full time and part-time staff had completed mandatory training with an overall compliance rate of 95%. Whilst the provider's 'developing people' policy referred to the aims and expectations of staff development, the policy did not outline which staff needed to receive which courses and how often these courses should be refreshed. The policy lacked clear specialist training

guidance for staff who worked with patients with addictions. The lack of guidance meant that there was a risk that staff were unaware of the training expectations needed to meet the needs of patients.

Assessing and managing risk to clients and staff

- Whilst the service had a risk assessment tool in place within the electronic care records, staff did not always ensure that they explored all areas of risk for patients undergoing the detoxification programme. Staffwere expected toundertake individual risk assessments on patients, which included an assessment of risk to themselves and others.However, in two out of nine records reviewed, we found that the junior doctor had failed to ask or consider if either patient had previously experienced alcohol withdrawal seizures or delirium tremens. Alcohol withdrawal seizures and delirium tremens are serious medical complications of alcohol detoxification and can cause death. The lack of assessment increased the risks that both patients could develop alcohol withdrawal seizures or delirium tremens, which would put them at risk of serious harm.
- Staff did not always ensure that they risk assessed patients who had or were in contact with vulnerable children and adults. In two out of nine records, we found that these patients had young children. Staff failed to escalate and manage the potential safeguarding risks to these children in order to protect them harm. In one other record, staff had not asked the patient whether they had children or other dependents.
- Staff did not consistently carry out brief cognitive assessments on patients who had been admitted for alcohol detoxification. In two out of nine records, we found that patients were not appropriately assessed prior to treatment commencing. In one record, the staff member had recorded 'no concerns' for this part of the assessment. In another record, there was no record that a cognitive assessment had been completed on admission. A cognitive assessment is a formal assessment of a person's thinking processes, such as memory and concentration. The lack of assessment meant that staff would not identify the signs and symptoms of alcohol-related brain damage. If this is not detected early, the condition can lead to permanent brain damage or death.
- Staff ensured that when patients were identified as being unwell that this was escalated to a doctor. We saw one example of a patient being referred to an acute hospital due to the deterioration in their physical health.
- Patients were not allowed to smoke on the ward. Patients were required to smoke in a designated smoking area in the garden or outside of the hospital grounds.
- The ward staff had not carried out any physical interventions on patients in the past 12 months. Physical interventions were not required for the patient group undergoing detoxification. Staff told us that they had not been involved in restraining any patients but had been trained in the prevention and management of violence and aggression.
- The ward staff had not administered any rapid tranquilisation medicines to patients in the past 12 months. The provider had a policy in place for staff to refer to.
- All members of staff had completed training in safeguarding vulnerable adults and children at risk. The hospital had a safeguarding lead who was a qualified social worker. Staff recognised the different signs of abuse and understood how to escalate a safeguarding concern.
- Children who were aged under 12 were not allowed to visit the ward. Staff booked separate spaces off the ward for family visits.
- Staff accessed patient treatment records mostly by an electronic care record system. Paper files were in place, but these documents were uploaded onto the patients' electronic file. Bank and agency staff were given individual computer accounts in order to ensure that they were able to access and document patient information.
- Staff handled and stored medicines safely, but they did not always ensure that they sufficiently recorded the decision making process for the administration of medicine to a patient. We found in one record a patient was prescribed a variable dose of a medicine used for alcohol detoxification, but staff had not recorded how they had come to the decision to administer a higher dose on two different occasions. The alcohol withdrawal tool used with the patient demonstrated that the

patient was experiencing low levels of withdrawal symptoms, but the dose given did not reflect this. The lack of recording of the decision-making process meant that the patient could be at risk of not receiving the correct medication in order to stop the progression of alcohol withdrawal symptoms.

- During the inspection, two patients reported to us that some staff had made medicine errors and felt that they had to recheck their medicines once dispensed themselves. This was escalated to the deputy ward manager to be investigated.
- Patients were regularly reviewed by their doctor in line with NICE guidance. Medication was monitored by the junior doctors and by the consultant psychiatrist who was in charge of the patient's admission.

Track record on safety

- No serious incidents had occurred in the past 12 months that related to the patients undergoing addictions treatments.

Reporting incidents and learning from when things go wrong

- Staff understood how to raise an incident via the electronic incident reporting system. Staff were aware of what incidents should be reported.
- The ward manager attended the weekly learning and outcomes group meeting. This meeting is an opportunity for senior staff to discuss incidents, safeguarding's and patients who are deemed to be a high risk. The meeting gave staff the opportunity to learn from incidents from other parts of the hospital.
- Incidents and learning outcomes were regularly discussed on the ward. Staff told us that incidents were discussed at the monthly team meeting. Meeting minutes demonstrated that feedback from incidents was an agenda item and staff discussed the learning from incidents. For staff that were unable to attend the meeting, the ward manager emailed the feedback and the provider sent out a 'monthly learning bulletin', which included alerts to staff. As a result of incidents on other wards, staff were expected to report any staffing issues in the morning hospital meeting to ensure that sufficient staffing could cover the emergency response and team incident reviews should be carried out after any restraint or reported incident.

Duty of candour

- Staff were aware of the term duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- The ward manager told us an example of when duty of candour had been applied following an incident in September 2017. Staff ensured that the patient understood the incident that had occurred and supported the patient during the investigation process.

Are substance misuse/detoxification services effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- Medical staff did not always complete good quality initial assessments and carry out the appropriate physical health checks in accordance with National Institute for Health and Care Excellence (NICE) guidance. In three out of nine records, patients had not received a full medical assessment on admission. One record did not demonstrate that the admitting doctor had measured the patient's height, weight, or body mass index despite the patient having a history of an eating disorder. The doctor had not carried out liver function blood tests prior to treatment commencing and had not ensured that the patient completed a pregnancy test. Another clinical record demonstrated that staff had carried out the patient's basic physical health checks (blood pressure and pulse) five days after admission. The lack of initial physical health checks meant that staff could not be assured that patients had no physical health complications prior to starting a detoxification programme. Staff had not followed the provider's own medically assisted withdrawal policy, which stated that on admission, all patients should have a "full medical assessment" and the patient's physical status should be observed and recorded.
- Staff did not always ensure that prior to treatment commencing and during admission, patients completed alcohol and drug testing. In three out of nine records, there was no record to demonstrate that any of the

patients had completed a random drug screening prior to treatment commencing. The lack of drug and alcohol testing meant that staff could not be assured that patients were providing an accurate account of their substance misuse prior to treatment commencing. This did not follow best practice guidance.

- Overall, care plans were completed to a good standard. We reviewed nine care plans and found that they were detailed and included the view of the patient. Care plans included sections on keeping well and healthy, keeping connected with friends and family, and keeping safe. Although care plans were in place, patients we spoke with told us that they did not always receive a copy or were not involved in creating the care plan. Patients told us that some nursing staff created the care plan and asked the patient to sign it off. Results from clinical audits demonstrated that care plans required more carer involvement.
- Staff offered patients a blood borne virus (BBV) screening and vaccine. This was based on the patient's drug history. This tested for blood borne viruses link hepatitis B, hepatitis C and HIV.

Best practice in treatment and care

- Staff used recognised withdrawal tools only such as CIWA-Ar (clinical institute withdrawal assessment for alcohol) and COWS (clinical opiate withdrawal scale).
- Staff did not always follow best practice guidance when assessing the severity of a patient's withdrawal symptoms. At the time of the inspection, the provider's first version of the 'Guidelines for Medically Assisted Withdrawal' policy did not clearly demonstrate the decision making process for staff to follow when deciding on the variable dose of medicine to administer to a patient following the completion of a CIWA-Ar (a type of alcohol withdrawal tool). The lack of guidance increased the risk of inconsistency between nursing staff because the CIWA-Ar total scores were open to interpretation by the assessing nurse. This increased the risk of patients receiving a lower dose of medicine and the progression of alcohol withdrawal symptoms may not be minimised. However, following the inspection the provider had plans in place to implement a new system to ensure the decision making process was safer.
- Patients had access to a wide range of psychological therapies including cognitive behavioural therapy. The service wanted to expand the therapies offered and had plans to recruit an eye movement desensitisation and re-processing (EMDR) therapist. The service offered a 28 day admission and patients followed a '12 step programme' which is commonly used for alcohol addiction.
- Patients were offered a lifetime of free aftercare which consisted of weekly group therapy. Families were offered to join the aftercare programme. Patients had good access to physical healthcare when required. The ward was able to access specialist doctors.
- The ward used Health of the Nation Outcome scales and patient satisfaction survey to assess whether patients had an effective admission. The hospital used a patient questionnaire to monitor their progress with their treatment.
- Whilst the ward manager carried out clinical audits, which included the monitoring and recording of physical health checks, quality of risk assessments and care plans, the ward did not audit whether staff had completed withdrawal tool assessments for patients. The lack of close monitoring of the tools meant that the provider could not be assured that staff scored withdrawal tools accurately and consistently.

Skilled staff to deliver care

- The ward employed qualified nurses, HCAs, psychiatrists and a range of specialist addiction therapists who worked in a separate department. The therapies department employed peer support workers who were ex-patients. The peer support workers provided support and advice to patients undergoing the addiction therapy programme. The ward had access to a hospital social worker.
- The ward offered HCAs the opportunity to complete the care certificate. At the time of the inspection, one out of five HCAs had completed the certificate. The care certificate is a programme suitable for HCAs who are new to care and support. The deputy ward manager, who was the care certificate lead, reported that due to changes in the team, there had been challenges in permanent staff and agency staff completing areas of the programme. The deputy ward manager was sighted on the issue and had a plan to ensure staff continued with the programme.

Substance misuse/detoxification

- The provider expected all qualified nurses to complete a medicine competency assessment as nursing staff had not received specialist training in substance misuse. During our first inspection on 9 and 10 November 2017, staff reported that they had not received any formal training in recognising the signs of alcohol or drug withdrawal symptoms, how to recognise and monitor alcohol induced seizures and delirium tremens, and how to use withdrawal tools. Staff received training that had been verbal only. Some members of staff did not recognise the names of recognised withdrawal tools and unaware of the term 'delirium tremens'. This posed a risk to patient safety as the provider could not be assured that staff could safely manage and monitor patients undergoing detoxification.
- During our second inspection on 21 November 2017, the provider implemented a 'medically assisted competency checklist'. However, we found that the learning from this had not yet been embedded into nursing practice. Nursing staff had a varied understanding in their approach to completing CIWA-Ar (Clinical Institute Withdrawal Assessment of Alcohol Scale) forms and interpreting the total scores. We found in two separate clinical records that there was no record to explain how nurses decided the dosage of PRN (as required) medicine to be administered and in what circumstances. We found in one record that the CIWA-Ar was poorly completed. Staff had not recorded the monitoring of the patient's blood pressure and pulse, and areas of the form had not been scored. This meant that the extent of the patient's withdrawal symptoms may have been underestimated.
- Staff did not use the CIWA-Ar total score to guide the PRN dosage administered to the patient. We found in one clinical record that staff had administered on two separate occasions 20mg of a medication used for alcohol detoxification, although the CIWA-Ar score showed low levels of withdrawal symptoms. Staff had not recorded their reason for the administration. The level of inconsistency was unsafe and increased the risks of patients not receiving the correct dose of medicine, in a timely manner, in order to prevent the progression of alcohol withdrawal symptoms. Withdrawal symptoms that are not closely monitored and treated could lead to seizures and other serious complications.
- Whilst staff told us that they received regular supervision and attended reflective practice, supervision records did not always demonstrate that staff received regular supervision. Supervision records showed that 36% of staff had not received managerial supervision between January to October 2017. Between June and October 2017, supervision records demonstrated an improvement in the completion of supervision meetings. The lack of recording of supervision meetings meant the provider could not be assured that staff were appropriately supported.
- One hundred percent of staff had received an appraisal in the past 12 months.
- The ward manager dealt with matters concerning staff employment and performance. Results from clinical audits were followed up with individual members of staff.

Multidisciplinary and inter-agency team work

- The ward had multidisciplinary (MDT) team meetings between nurses, healthcare assistants, and ward doctors. Consultant psychiatrists met with nursing staff when they visited their patient on the ward.
- Nursing staff had a handover twice a day when the shifts changed. The nurse in charge also provided a handover to the therapy staff mid-morning. The handover sheet was detailed and included all patient risks and the frequency of physical health checks for each patient. The handover sheet was easily accessible for all staff in the nursing office.
- On discharge staff ensured that a detailed patient discharge summary was sent to relevant community, professionals such as GPs. Patients consented for information to be shared.

Adherence to the Mental Health Act

- Ninety-five percent of ward staff had completed Mental Health Act training as part of the hospital training programme.
- Patients who completed the addiction treatment programme were not detained under the MHA due to the nature of the treatment. There had been no detentions in the past 12 months.

Good practice in applying the Mental Capacity Act

Substance misuse/detoxification

- Ninety-five percent of ward staff had completed Mental Capacity Act training as part of the hospital training programme.
- Patients voluntarily approached the service for treatment and they were presumed to have the capacity to consent. On admission, patients' capacity to consent to treatment was assessed if there was a concern.
- Most staff were able to explain the five guiding principles for assessing a person's capacity. One nurse was unable to recall parts of the assessment. All staff informed us that they would escalate to a doctor if they had concerns about a patient's capacity.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- During the inspection, we observed staff being friendly, support, and caring towards patients. Staff were respectful and responsive to patients' needs.
- Patients mostly told us that staff communicated well and were quick in their responses to patient need. Patients gave us some examples of doctors who had been 'life savers' and were 'positively challenging'.
- Staff understood the needs of patients and appeared to have formed strong relationships with them.
- Staff understood and felt confident to raise concerns without fear of victimisation. Staff felt well supported and cared for.
- Staff protected patients' confidentiality by recording patient information on whiteboards that could be covered. We observed that staff were discreet when reviewing the whiteboard.

The involvement of clients in the care they receive

- The ward had an admission checklist, which included showing patients around the ward. All patients were orientated to the ward on arrival. We found that most staff fully completed the checklists.
- Patients told us that they did not always feel that care plans were created collaboratively with the patient. Some patients told us that care plans were created by staff and shown to the patient once completed. The monthly clinical audits reflected that staff needed to improve carer involvement in care plans.
- Patients were able to give feedback to the ward and wider hospital. This was mostly through the patient satisfaction surveys, which were reviewed by senior managers. We saw evidence that poor feedback was listened to and addressed. For example, a patient was unhappy with the limited meal options. This was addressed with the hospital catering staff. During the inspection, we observed that the ward had received thank you cards from patients. Staff appreciated the recognition of their work. The ward manager told us that feedback had been collected via the NHS choices website, which was shared with staff and the wider hospital.
- Families and carers were invited to attend the twice monthly family programme. This was a part of the provider's free aftercare for the addiction programme.

Are substance misuse/detoxification services responsive to people's needs? (for example, to feedback?)

Access and discharge

- The ward was a private mixed acute psychiatric admission ward and a ward for people undergoing the addictions therapy programme. Beds were not specifically allocated to either patient group. Beds were available as required.
- The ward accepted patients from across the UK. However, most patients admitted to the ward were located within the London region.
- Patients were allocated to a bedroom for the duration of their treatment. Patients were not moved to other wards.
- Discharges were planned during treatment. Staff ensured that discharge summaries were sent to professionals in the community such as the GP.

The facilities promote recovery, comfort, dignity and confidentiality

Substance misuse/detoxification

- Patients had their own bedrooms with an ensuite. During the inspection, we found that two bedrooms were closed due to the CQC raising concerns at our last inspection. The bedrooms were being converted in to a family room and the ward manager's office.
- Patients could personalise their own bedrooms. Patients had personal safety boxes within each bedroom to store their possessions.
- The ward offered consultation rooms to support treatment. Therapy rooms were based on a separate floor.
- Patients used their own mobile phones to make private phone calls.
- Patients had access to a communal garden space and the grounds of the hospital.
- Patients were able to make hot drinks and snacks on the ward. The hospital restaurant offered a range of food and meals.

Meeting the needs of all clients

- The environment of the ward did not support patients who had protected characteristics. The ward was unable to admit patients who had a physical disability or limited mobility. This was because there was no lift to reach the ward. The toilets did not support people with mobility impairments.
- Patients had access to information relating to mutual aid groups offered at the hospital to support them with alcohol and narcotic addictions. Staff were able to source support group information where needed including in different formats and languages.
- Patients were able to access spiritual support in the community where needed. The hospital had a chaplain.

Equality and human rights

- Staff told us how patients from an LGBT+ (lesbian, gay, bisexual and transgender) background would be accommodated. Staff reported that transgender patients would be accommodated in either the male or female corridor, depending on how the patient identified them self. Staff were aware of the LGBT+ support groups based in central London. The ward did not have an LGBT+ lead in place for staff and patients to approach.

Management of transition arrangements, referral and discharge

- Patients mainly self-referred for treatment. Patients either self-funded or used their private health insurance to fund their care and treatment.

Listening to and learning from concerns and complaints

- The provider had a complaints policy in place and staff reminded patients in the weekly meeting of the complaints process.
- The ward had received no complaints in the past 12 months. The provider kept a complaints register including the outcome of each complaint.
- Patients we spoke knew how to raise concerns about their care and treatment. Patients gave us examples of when they were unhappy and raised their concern to the nursing team.
- Complaints across the hospital were discussed in the monthly learning outcomes group. Ward managers attended this meeting and fed back to ward staff the themes and outcomes from complaints.

Are substance misuse/detoxification services well-led?

Vision and values

- Staff we spoke with understood the vision of the service. Staff aimed to help people recover from their addiction. We saw that the providers values were displayed on posters around the hospital. Senior managers acknowledged that areas of practice required improvement and were keen to address the concerns in order to ensure patients received safe care and treatment.

Good governance

- The governance system in place did not proactively highlight the issues related to unsafe drug and alcohol detoxifications. We found that patients did not receive a full medical assessment on admission, patients did not

receive appropriate physical health checks prior to treatment commencing and staff lacked sufficient skills and knowledge to meet the needs of patients. These issues had not been identified by the provider.

- There was a lack of effective leadership in the addictions service. We found that clinical leaders were not always sighted on how the team was monitoring the quality and safety of the service. Some senior members of staff lacked knowledge of the auditing systems in place and were unable to refer to current national guidance used in drug and alcohol detoxifications. Effective systems had not been put in place to ensure that practice improved following clinical audits.
- Following our inspection of the service, the provider sent us a detailed action plan which demonstrated how the provider intended to address the concerns. The provider was committed to ensuring that the concerns we identified would be addressed within a short timescale.
- The provider had clear systems in place for reporting incidents and safeguarding alerts, although staff had not made all relevant referrals. We found that the provider had various ways of communicating learning from incidents, such as the 'monthly learning bulletin' and the monthly learning outcomes group.
- The provider had a risk register in place for the hospital. The risk register was reviewed and managed by senior managers. The risk register included environmental risks and recruitment.
- Staff and managers had access to the appropriate equipment and technology in order to carry out their work. Staff recorded patient notes on a secure electronic system.
- The provider ensured that reportable incidents were submitted to the CQC as required.

Leadership, morale and staff engagement

- There was good staff morale on the ward. Staff we spoke with were positive about their work and felt that their colleagues and managers supported them. Staff told us that the ward manager was approachable and felt confident to raise concerns.
- The provider had put in place various opportunities for staff to be recognised for their hard work and contribution to practice. For example, the provider held an event called the 'pride awards'. This was an awards ceremony for nominated staff who demonstrated the values of the provider. The provider also asked staff to vote for 'employee of the month'. Staff won a 'duvet day' as a reward.

Outstanding practice and areas for improvement

Outstanding practice

Outstanding practice

- The psychologist on Priory Court provided carer skills training based on the Maudsley communication styles model for supporting parents with communication and parenting styles.
- Staff on Lower Court had a proactive approach to ensure sure temporary staff were familiar to the ward. They had produced a one-page document that outlined tips for staff working on a CAMHS ward. This document was clearly displayed in the nursing office.
- The wards had incorporated 'safewards' a model aimed at decreasing incidents of violence and aggression on wards using different interventions. We saw that acute wards and the CAMHS ward had introduced self-soothe boxes that contained items chosen by each patient to utilise at times of distress.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the East Wing service for acute patients is relocated to a safer environment with less potential risks as soon as possible.
- The provider must ensure they meet timescales for the renovations of West Wing and Garden Wing to create a safe environment for acutely unwell patients. The provider must review whether they feel sufficient mitigations are in place to keep patients safe during the renovation period. The provider must ensure they keep stakeholders including the CQC updated on their progress.
- The provider must ensure that systems are put in place to check on mandatory training undertaken by junior doctors working on the wards.
- The provider must ensure that patients on Garden Wing have privacy on the ward and that their dignity is not compromised.
- The provider must ensure that they meet agreed timescales to refurbish the small dining room on Upper Court, to provide a positive therapeutic environment.
- The provider must ensure that staff on West Wing comprehensively assess and appropriately manage risks for patients with substance misuse needs on admission. This includes assessing for alcohol related seizures and delirium tremens, completing cognitive assessments prior to treatment commencing and assessing whether the patient is in contact with dependent adults or children.
- The provider must ensure that staff on West Wing supporting patients with substance misuse needs have the correct skills, knowledge and competence to recognise withdrawal symptoms and complete relevant withdrawal tools accurately. This includes staff recording how they come to a decision to administer a specific dose to a patient requiring PRN (as required) medication.
- The provider must ensure that medical and nursing staff on West Wing supporting patients with substance misuse needs carry out comprehensive physical health checks and drug testing prior to treatment commencing. This includes staff carrying out relevant blood tests and pregnancy tests.
- The provider must ensure that there are governance systems in place to assess, monitor, and improve the quality and safety of the substance misuse service on West Wing.

Action the provider SHOULD take to improve

- The provider should continue to monitor staff completion of vital signs for all patients following rapid tranquilisation.

Outstanding practice and areas for improvement

- The provider should ensure all staff are competent to undertake calibration of blood glucose monitoring machines.
- The provider should ensure they continue to deploy agency staff that are familiar with the wards to ensure consistency in patient care.
- The provider's training policy should outline the training expectations to safely deliver care and treatment to specialised patient groups such as eating disorder and addictions. Staff should ensure they deploy agency staff who are appropriately trained to work on eating disorder wards and addiction wards.
- The provider should ensure that on West Wing all emergency equipment is included on the emergency bag checklist and staff raise any issues with clinical equipment without delay.
- The provider should ensure that on West Wing supervision meetings are recorded in the supervision log.
- The provider should ensure that in the future West Wing can accommodate and support patients who have a physical disability or limited mobility.
- The provider should ensure that patients on West Wing are included within the care planning process and receive a copy of the care plan once completed.
- The provider should ensure that a suitable environment is provided for the physical examination of patients on Garden Wing.
- The provider should ensure the safe management of medicines. The provider should ensure that sufficient information is made available to staff administering PRN (as and when) medicines regarding the dose to be administered. The provider should ensure on Lower Court that all medication where appropriate have labels indicating open dates. The provider should ensure that all medicines given to patients on Garden Wing for home leave are recorded on medicines administration records, and monitor the practice of agency nurses administering medicines to patients.
- The provider should ensure that further action is undertaken to address issues of staff retention on Garden Wing.
- The provider should consider provision of more activities for patients on the acute wards on Sundays.
- The provider should ensure that all ward areas on Lower Court are clean and well maintained. The provider should ensure that cleaning records on Lower Court demonstrate that all ward areas have been cleaned regularly, in particular the kitchen area
- The provider should ensure care plans on the eating disorder wards are updated promptly when there has been a change in patient risk.
- The provider should review the outdoor lightening to ensure it is safe for patients and staff to access the grounds after dark.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The East Wing service needed to be relocated as the current environment had too many potential risks for patient safety. The provider needed to ensure they met timescales for the renovations of West Wing and Garden Wing to create a safe environment for acutely unwell patients. This was a breach of Regulation 12(1)(2)(a)(b)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Patients on Garden Wing did not have access to private areas and this compromised patient dignity. The dining area on Upper Court was not large enough and did not provide a therapeutic environment for patients with eating disorders Whilst building work was planned to address these areas, there was still a significant period of time before they were to be addressed. This was a breach of Regulation 10(1)(2)(a)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that systems were put in place to check on mandatory training undertaken by junior doctors working on the wards. This was breach of Regulation 18 (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment On West Wing, the provider did not ensure that for patients being admitted for a substance misuse service that staff comprehensively assessed and appropriately managed patient risk on admission. This included assessing for alcohol related seizures and delirium tremens, completing cognitive assessments prior to treatment commencing and assessing whether the patient is in contact with dependent adults or children. On West Wing, the provider did not ensure that medical and nursing staff carried out comprehensive physical health checks and drug testing prior to treatment commencing. This included staff carrying out relevant blood tests and pregnancy tests. This was a breach of regulation 12(1)(2)(a)(b)(c)(i).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance On West Wing, the provider did not ensure that there were governance systems in place to assess, monitor, and improve the quality and safety of the service. This was a breach of regulation17(1)(2)(a)(b).

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing On West Wing, the provider did not ensure that staff had the correct skills, knowledge and competence to recognise withdrawal symptoms and complete relevant withdrawal tools accurately. This included staff recording how they come to a decision to administer a specific dose to a patient requiring PRN (as required) medication. This was a breach of regulation 18(2)(a)