

The Priory Hospital Chelmsford

Quality Report

Stump Lane
Springfield Green
Chelmsford

Essex
CM17SJ

Tel: 01245 806412

Website: www.priorygroup.com

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

Ratings

Overall rating for this location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



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

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

Summary of findings

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

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

Overall summary

We rated The Priory Hospital Chelmsford as requires improvement because:

- The provider had not ensured that they identified and mitigated all risks on the wards, including ligature risks, and prescribing errors. They did not have enough staff on the Children and Adolescent Mental health wards to keep young people safe. The Children and Adult Mental Health ward had experienced high levels of incident reports related to staffing levels, but the provider had not acted to resolve the issues.
- Pharmacy staff and Mental Health Act internal audits had highlighted issues with prescribing and administration of medicine, but staff had not resolved all of these issues. Managers had not acted to address issues with staff performance in these areas. We found issues with storage of medicines and record keeping on one ward.
- Staff on Springfield and Chelmer wards had not completed all their mandatory training.
- Staff did not assess the physical and mental health of all patients in an individualised way.
- The provider's governance system was not robust enough to ensure the safe care and treatment of

patients. Managers had not identified problems with risk assessments and medicines audits and did not keep appropriate records of agency staff work experience.

However:

- The hospital provided a full multidisciplinary team and treatments in line with national guidance and best practice.
- Staff completed and updated risk assessments for each patient and used them to formulate care plans to manage those risks. The service managed complaints and incidents well and learned from them through meetings and bulletins. Managers used lessons learned and introduced new ways to improve patient safety.
- Staff on the adult acute wards treated patients with compassion and kindness, respected their privacy and dignity and involved their family members in decisions about their care.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity.
- Patients were positive about the care and treatment they received at the hospital and staff supported them to maintain contact with the local community and their friends and relatives.

Summary of findings

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Requires improvement



The Priory Hospital Chelmsford

Services we looked at

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

Child and adolescent mental health wards

Substance misuse services

Summary of this inspection

Background to The Priory Hospital Chelmsford

Priory Healthcare Limited is the registered provider for the Priory Hospital Chelmsford, an independent mental health hospital providing 60 beds. The Care Quality Commission registered The Priory Hospital Chelmsford to carry out the following regulated activities:

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

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

The services at this hospital include:

Acute wards for adults of working age:

- Chelmer ward, a 16 bedded mixed sex acute ward for assessment of patients with mental health needs which also provided care to some patients with addictions.

- Danbury ward, a 12 bedded mixed sex acute ward providing inpatient beds for assessment and treatment of patients with mental health needs.
- Springfield ward, a 12 bedded mixed sex ward providing assessment and treatment for patients with an eating disorder.

Substance Misuse Services

- Chelmer ward, a 16 bedded ward which treated patients who required detoxification alongside patients with mental health needs.
- The Lodge, a three bedded mixed sex house for patients receiving the addictions therapy rehabilitation programme.

Child and adolescent mental health wards (CAMHS):

- CAMHS ward, a 17 bedded mixed sex ward providing assessment and treatment for children and adolescents with mental health needs.

Our inspection team

The team that inspected the service comprised three CQC inspectors, two inspection managers and two specialist advisers with experience of working in mental health services and two experts by experience with experience of child and adolescent mental health services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of this inspection

This inspection was announced.

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

During the inspection visit, the inspection team:

- visited all five wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 14 patients who were using the service;
- spoke with four family members of patients who were using the service;
- spoke with the registered manager and managers for each of the wards;
- spoke with 15 other staff members; including doctors, nurses, and psychologists.
- spoke with an independent advocate;
- attended and observed a range of meetings and reviewed minutes from others;
- Looked at 36 care and treatment records of patients;
- carried out a specific check of the medicines management across the hospital; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients on acute wards told us that staff were kind and caring and treated them with respect. Patients on these wards felt they were involved in the planning of their care and could raise concerns through several methods.

Patients on the children and adolescent mental health ward told us that staff were usually kind and caring, however a group of seven patients told us staff did not always treat them with compassion and kindness or

respect patients' privacy and dignity. These patients told us that staff had threatened them and blamed their behaviour for short staffing and that night staff were rude and woke them up at night. Family members told us that staff were always kind and helpful. They told us staff invited them to meetings and staff provided information about their relative's care where appropriate.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as requires improvement because;

- The provider had not ensured that the ward environments were safe and well maintained on Chelmer ward. There were ligature points on the wards which staff had not identified or properly mitigated.
- Staff did not follow best practice when storing, giving, and recording medicines. We found out of date medicines on Danbury ward and on Chelmer ward prescription charts were not clearly written.
- The service did not have enough nursing staff on the children and adolescent mental health wards to keep young people safe from avoidable harm during incidents.

However;

- Staff completed and updated risk assessments for each patient and used these to understand and manage risks individually.
- Staff kept detailed records of patients' care and treatment on a secure electronic system.
- The service learned from patient incidents through meetings and bulletins.

Requires improvement



Are services effective?

We rated effective as good because;

- Staff provided treatments and care for patients based on national guidance and best practice.
- Staff from different disciplines, including nurses, doctors, therapists, social workers and psychologists, worked together as a team to benefit patients.
- Staff understood their responsibilities under the Mental Capacity Act 2005 and supported patients to make decisions on their care for themselves.

However;

- Staff did not assess the physical and mental health of all patients in an individualised way.
- Staff had not followed legal procedures relating to prescribing medication under the Mental Health Act 1983. Two prescriptions did not match details of medications agreed to in consent to treatment forms.
- The provider had not kept thorough records of the relevant work experience of agency staff working in the hospital.

Good



Summary of this inspection

Are services caring?

We rated caring good because;

- Most patients informed us that staff treated them with compassion and kindness and respected their privacy and dignity.
- Staff on acute wards involved patients and their family members in decisions about their care. Family members and carers felt included in the patients' care and the provider routinely invited them to meetings.

However;

- We received mixed feedback from patients on the Children and Adolescent Mental Health ward.

Good



Are services responsive?

We rated responsive as good because;

- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Patients had their own bedrooms and access to quiet spaces.
- Staff ensured that patients maintained contact with the wider community through visits to the local community and local groups.
- The service treated concerns and complaints seriously. Managers thoroughly investigated incidents, and shared lessons learned with staff through meetings and supervision.

However;

- Chelmer ward was not accessible to patients with mobility issues as accommodation was located on the first floor and there was no lift. Staff could admit patients with reduced mobility to Danbury ward instead where there was a lift.

Good



Are services well-led?

We rated well-led as requires improvement because;

- The provider's governance system was not robust enough to ensure the safe care and treatment of patients. Managers did not have enough oversight of ligature risks and had not remedied actions from medicines audits.
- The provider had not ensured that medical staff were resolving errors relating to prescribing.
- There were insufficient staff on the Children and Adolescent Mental Health ward, the provider had recognised this but not acted to resolve it.

Requires improvement



Summary of this inspection

- The provider kept employment records of the agency staff who worked at the hospital but these records did not contain details of their work experience.

However;

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.

Detailed findings from this inspection

Mental Health Act responsibilities

- Nursing staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and how these applied to adults and children. However, we found evidence in prescription records that medical staff had not followed legal procedures relating to prescribing medication under the Mental Health Act.
- We reviewed the paperwork for eight patients detained under the Mental Health Act. Paperwork was present and complete, however, the information written on two consent to treatment forms did not match the prescription cards.
- We found that some notes concerning patients, who were having treatment on an informal basis, used legal terms used for patients detained under the Act.
- Ninety-five per cent of staff had attended annual training on the Mental Health Act 1983 and administrative support was available on site three days per week.
- Staff explained patient rights under the Mental Health Act 1983 when required and whenever there were changes in circumstances.
- An independent mental health advocate visited the wards on a weekly basis to support patients with their rights and concerns.
- The Mental Health Act administrator completed a monthly audit of Mental Health Act paperwork to ensure that the ward was meeting the legal requirements of the Act.
- Staff had access to the provider's policies surrounding the Mental Health Act and the Code of Practice.
- Staff ensured that patients had access to section 17 leave. Staff requested an opinion from a second opinion appointed doctor when necessary. Staff stored copies of patients' detention papers and associated records correctly.
- The service displayed notices to tell informal patients that they were free to leave the ward if they wished.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff supported patients who lacked capacity to make decisions for themselves about their care and treatment. Staff understood when to apply the Mental Capacity Act 2005 in the case of adults and young people and assessed and recorded capacity clearly. We reviewed the records of 12 patients which demonstrated that staff had assessed patient capacity and there was informed consent to treatment.
- Staff received annual training on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and had access to administrative advice.
- Eighty-one per cent of staff had training in the Mental Capacity Act and staff we spoke with had a good understanding of the Mental Capacity Act.
- There were no Deprivation of Liberty Safeguards applications in the last 12 months.
- The provider had a policy on the Mental Capacity Act and Deprivation of Liberty Safeguards and staff had access to it.
- Staff assessed patients' capacity to consent to treatment and recorded their decision appropriately. When patients lacked capacity, staff made decisions in their best interests
- The provider monitored compliance with Mental Capacity Act policy through audits.

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	Good	Requires improvement	Requires improvement
Child and adolescent mental health wards	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Substance misuse services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

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

Requires improvement 

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

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

Requires improvement 

Safe and clean environment

- The provider had not ensured that all ward environments were safe and well maintained. Staff completed regular risk assessments of the care environment. However, on Chelmer ward the provider had bedrooms which they identified as safer rooms, designed to reduce risk of ligatures. We found fittings in these rooms were loose and patients at risk could use them as a ligature point. We found potential ligature anchor points in the stairwells which staff had not identified. A ligature anchor point is the term used to describe a point to which people might tie something to harm themselves.
- Staff had identified other ligature risks but not sufficiently mitigated them. Staff had identified the staircase on Chelmer as lower risk due to high staff traffic, however we observed this area to have low levels of staff traffic.
- The ward environments allowed staff to observe all parts of the ward using convex mirrors to mitigate blind spots.
- Staff had access to alarms to call for help in case of an incident.
- The wards had fully equipped clinic rooms with all the equipment needed to monitor patients' physical health and resuscitation equipment for emergencies. Staff maintained equipment and kept it clean.

- Chelmer and Danbury wards had separate floors for male and female accommodation which complied with standards set by the Department of Health.
- The wards were clean, and the furniture was well maintained.
- Staff had access to handwashing facilities and hand gel and followed infection control principles.

Safe staffing

- The service had enough nursing and medical staff; who knew the patients and received basic training to keep people safe from avoidable harm. However, two family members and patients told us there were not enough staff to support all activities on the ward therefore sometimes they had to cancel them.
- Chelmer ward had a staffing establishment of 6.4 whole time equivalent (WTE) nurses and 16.8 WTE healthcare assistants with 1.29 WTE nurse vacancies and 2.84 WTE healthcare assistant vacancies. Danbury had a staffing establishment of 6.4 WTE nurses and 7.7 WTE healthcare assistants with 1.1 WTE nurse vacancies. Springfield had a staffing establishment of 6.4 WTE nurses and 1.3 WTE healthcare assistants with 1.3 WTE nurse vacancies and 1.81 WTE healthcare assistant vacancies. We reviewed staffing rotas as for March and April 2019 and saw that agency staff and substantive staff overtime was used to cover sickness and observations where patients needed extra support. A qualified nurse was present on the wards at all times. Staffing levels were sufficient to carry out physical interventions and ensure that patients had a one to one time with their named nurse. Medical staff provided 24-hour cover through an on-call doctor rota, a doctor could attend the wards promptly if there was an emergency.
- Managers discussed staffing levels at the morning 'flash' meeting each day and had the authority to bring in

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

Requires improvement



additional staff when needed. Managers prioritised use of regular staff where possible and booked agency staff in block bookings. When managers booked agency staff, they booked those who were familiar with the patients on the ward and ensured they had a suitable induction. Short staffing rarely resulted in staff cancelling escorted leave of ward activities.

- Managers could increase staffing requirements to meet patient needs. Senior managers had reviewed and increased the basic staffing level from Danbury ward due to the accommodation being across two floors.
- Managers had not ensured that staff had the skills needed to provide high-quality care. We reviewed mandatory training records for all staff on the wards and found on Springfield and Chelmer wards three out of 78 training topics had compliance rates below 75%. Training topics where attendance was low, were essential for staff to do their jobs effectively. These included observation practice and rapid tranquilisation, which both had a compliance rate below 60%.

Assessing and managing risk to patients and staff

- Staff completed and updated risk assessments using a recognised risk assessment tool for each patient and used these to understand and manage specific risks for individuals. We reviewed 13 patient records and found all of them had a completed risk assessment from admission. Staff identified and responded to changing risks by updating risk assessments on a regular basis and when there had been an incident.
- Staff followed the provider's policy for the use of observations and completed the paperwork appropriately. Staff searched patients and their bedrooms according to the provider's procedures.
- Staff applied blanket restrictions on patients' freedom only when justified. Informal patients could leave at will.
- During the period of 1 July 2018 and 31 December 2018 there were 20 episodes of restraint on the acute wards. These were highest in Chelmer ward, and related to different patients. The wards did not use prone restraint or long-term segregation. Staff minimised their use of restrictive interventions through de-escalation techniques and followed best practice when using physical interventions on a patient. Staff did not use rapid tranquilisation or seclusion. We observed a restrictive intervention which staff completed safely and with dignity.

Safeguarding

- Staff knew how to identify safeguarding incidents but had not reported one on time. Training compliance with safeguarding was 92%. The team had a social worker who supported the safeguarding process by reviewing and following up any referrals made to the local authority. Staff were aware of the procedure for referrals and were able to give examples of how they could protect patients from abuse. All wards displayed posters on the referral process. Reports were made in a timely manner.
- Senior staff reviewed safeguarding cases and concerns each month at the lessons learned meeting. The social worker provided feedback at this meeting on the actions taken by the local authority and any protective measures in place.
- The wards had safe procedures for when children visited patients at the service. There was an allocated room for patients to meet with visitors.

Staff access to essential information

- Staff kept detailed records of patients' care and treatment on a secure electronic system.
- Patient records were clear, up-to-date and easily available to all staff providing care, including agency staff.
- The service had a contingency plan should the electronic system fail. The ward manager kept paper backup records securely.

Medicines management

- Staff did not follow best practice when storing, giving and recording medicines. We checked the ward's medicine storage procedures and 27 prescription charts during the inspection. We found prescribing errors in six prescription charts. The pharmacist had highlighted some errors, but staff had not resolved these errors.
- The provider had multiple medication charts for some patients. These charts were difficult to follow as they had been numbered incorrectly. This meant that staff could not easily check if patients had been administered medication.
- Staff on Danbury had stored patients' own medicines together with stock medicine, some controlled drugs were out of date by three months and the pharmacy had not removed these for destruction.

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

Requires improvement



- Patients received information about the medicines they were taking. Staff could offer verbal or written advice in the form of leaflets. Patients told us that they understood their medicines and staff would review any concerns they had.
- Staff regularly reviewed the effects of medications on each patient's physical health through regular ward rounds and blood monitoring where appropriate.
- A local pharmacy managed the medicine stock for the ward. Staff could order any medicines needed and the pharmacy supplied it promptly. The pharmacist sent managers a monthly report on the wards' compliance to the service's medicines management policy, however, prescribers on the wards did not always act to resolve errors. The pharmacist had raised that medicines on two prescription charts did not match the consent to treatment forms, the prescriber had not remedied this. Managers had not acted to manage this performance issue.

Track record on safety

- Between 12 February 2018 and 27 December 2018 there had been two serious incidents on the acute wards at the hospital, one involving a ligature attempt and the other, inappropriate staff behaviour.
- Managers and staff were able to give an example of a recent serious incident where a patient had attempted to use a mattress handle as a ligature point. They explained how they had learned from this incident and had removed all other handles from the mattresses in the hospital.

Reporting incidents and learning from when things go wrong

- The service had not identified all types of incident, for example medicines errors. Managers held a monthly 'lessons learned' meeting to discuss recent incidents and what they could learn from them. We reviewed ward meeting minutes and found staff discussed lessons learned regularly and this was a standing agenda item. All staff, including agency staff had access to the electronic reporting system.
- Managers arranged for staff to debrief following a serious incident alongside a psychologist and a senior manager.
- Staff had not recognised prescribing errors and poor medicines management as incidents and therefore had not reported them.

- Staff understood duty of candour, they were open and transparent when things went wrong. Managers wrote to patients and their families to apologise when an incident occurred.
- Managers investigated incidents that staff had reported, and shared lessons learned with the whole team and the wider service. Managers sent information from the provider about incidents which had happened nationally through ward meetings. Staff gave examples of how practice had changed as a result of incident reporting.

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 made care plans which met patients' needs and updated them regularly and when an incident occurred. We reviewed 13 patient records and found nine were personalised, holistic and recovery orientated.

Best practice in treatment and care

- Staff provided a range of treatments and care for patients based on national guidance and best practice.
- Patients had access to psychological therapies such as dialectical behavioural therapy, emotional regulation and cognitive behavioural therapy.
- Staff ensured that patients had good access to physical healthcare specialists. A dietician visited patients with eating disorders on Springfield ward to ensure that the provider met patients' needs for food and drink.
- Staff supported patients to live healthier lives by organising walks in the local areas, giving advice on healthy eating and smoking cessation.
- Staff used recognised ratings scales such as the Health Of the Nation Outcome Scale to assess patient outcomes.
- During the inspection we did not see staff using technology to support patients.

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

Requires improvement 

- Staff participated in clinical audit, benchmarking and quality improvement initiatives. Each manager had access to data showing how their ward was performing against others in the hospital.

Skilled staff to deliver care

- The team included staff from a range of disciplines including doctors, nurses, occupational therapist, clinical psychologists, social workers, dieticians and healthcare assistants.
- Managers told us they had difficulty booking some staff on training as the provider held training sessions at other hospitals within the Priory group. The service was working to resolve this by training local staff to train others in topics including safeguarding and management of violence and aggression.
- Managers supported staff with annual appraisals and monthly supervision and ensured staff received an appropriate induction. The percentage of staff that had an appraisal in the last 12 months was 100%. The percentage of staff that had clinical supervision regularly was 92%. However, in the staff records we reviewed, supervision records on Chelmer ward lacked detail and managers had not given actions a timeframe for completion or follow up. Managers ensured that staff had regular team meetings and kept minutes so that staff who could not attend received updates.
- The provider identified staff learning needs and gave staff opportunities to update and further develop their skills, through continuing professional development sessions and courses offered through the provider's online training system. This included specialist training for their roles.
- Permanent staff were experienced and qualified to meet the needs of the patient group.
- Managers ensured that agency staff had appropriate training to work on the ward. However, of the 12 agency profiles we reviewed, none included details of the relevant work experience the staff member had for the patient group. Some patients told us that agency staff did not know enough about their needs to provide high quality care.
- The service had not had to suspend, or performance manage any staff in the last 12 months.

Multi-disciplinary and inter-agency team work

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to

make sure patients had no gaps in their care. The multidisciplinary team included social workers, occupational therapy, nurses, psychologists, doctors, dieticians and therapists.

- Staff from a range of disciplines would attend a morning 'flash' meeting where staff could hand over concerns to each other and agree actions. Human resources team members attended this meeting to help co-ordinate staffing needs but did not join in the clinical discussions about patient needs. A Mental Health Act reviewer attended the meeting and identified patients who may need their rights reviewed under the Mental Health Act.
- Staff from each discipline attended weekly meetings, ward rounds and lessons learned meetings. We observed four meetings and saw that staff involved, collaborated to keep patients safe and aid their recovery.
- Staff held twice daily handover meetings where they discussed patients' needs for the day and any changes which had occurred.
- The hospital had good links with the local authority. A social worker took the lead in liaising with the local authority on matters of safeguarding and patient needs.

Adherence to the MHA and the MHA Code of Practice

- Nursing staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice, but we found evidence in prescription records that medical staff had not followed legal procedures relating to prescribing medication under the Mental Health Act. We reviewed the paperwork for six patients, detained under the Mental Health Act, which was present and complete. However, pharmacy audits had highlighted the information written on two consent to treatment forms did not match the prescription cards. We found that some notes concerning patients, who were being treated on an informal basis, used legal terms designed for patients detained under the Mental Health Act when they were not detained.
- We checked mandatory training records and found 90% of staff had attended annual training on the Mental Health Act and administrative support was available on site three days per week.
- Staff had access to the provider's policies surrounding the Mental Health Act and the Code of Practice.
- Staff explained patient rights under the Mental Health Act when required and whenever there were changes in

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

Requires improvement



circumstances. Staff ensured that patients had access to section 17 leave. Staff requested an opinion from a second opinion appointed doctor when necessary. Staff stored copies of patients' detention papers and associated records correctly.

- An independent mental health advocate visited the ward on a weekly basis to support patients with their rights and concerns.
- The Mental Health Act administrator completed a monthly audit of Mental Health Act paperwork to ensure that the ward was meeting the legal requirements of the Act.
- The service displayed notices to tell informal patients that they were free to leave the ward if they wished.

Good practice in applying the MCA

- Eighty-one percent of staff had training in the Mental Capacity Act and staff we spoke with had a good understanding of the Mental Capacity Act.
- There were no Deprivation of Liberty Safeguards applications in the last 12 months.
- The provider had a policy on the Mental Capacity Act and Deprivation of Liberty Safeguards and staff had access to it.
- Staff supported patients to make decisions on their care for themselves. They understood when to apply the Mental Capacity Act 2005 and assessed and recorded capacity clearly. We reviewed the records of 13 patients. All showed evidence that staff had assessed the patient's capacity and there was informed consent to treatment.
- Staff assessed patients' capacity to consent to treatment and recorded their decision appropriately. When patients lacked capacity, staff made decisions in their best interests
- Staff received annual training on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and had access to administrative advice.
- The provider monitored compliance with Mental Capacity Act policy through audits.

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

Good



Kindness, privacy, dignity, respect, compassion and support

- Staff treated patients with compassion and kindness and respected their privacy and dignity. Patients told us that staff treated them with dignity and respect. Family members were generally positive about the way staff treated their relatives and said they were respectful. Staff attitudes demonstrated that they were discreet, respectful and responsive.
- Staff supported patients' individual needs, assessing their cultural, mobility and language needs on arrival at the service.
- Staff supported patients to understand their care and treatment.
- Staff supported patients to access services outside the hospital when appropriate.
- Staff said they were comfortable raising concerns about disrespectful or abusive behaviour.
- Staff took steps to maintain confidentiality of patients.
- The provider had improved preserving patient dignity when staff conducted searches for contraband items, by having a private room near the entrance of the hospital with privacy screens.

Involvement in care

- Staff orientated patients and gave them information about the service when they admitted them to the wards.
- Patients said they were involved in decisions about their care and treatment. Staff completed risk assessments alongside patients. Staff communicated with patients about their care and treatment. They held ward round meetings which patients could attend and be involved in the decision-making. Family members told us they regularly attended these meetings. The wards also held a weekly community meeting, enabling patients to give feedback and to voice concerns and issues.

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

Requires improvement



- Family members told us that they were involved in their relative's care when it was appropriate, and staff invited them to attend meetings.
- However, staff did not always ensure patients had copies of their care plans. Of the six patient care plans reviewed we saw staff had not given four patients a copy and no reason was documented.
- Staff supported patients to access advocacy services.
- Staff kept family members involved in the care and treatment of their relative and gave them opportunities to give feedback.

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

Good



Access and discharge

- Staff received information about each patient from a central admissions team prior to their arrival. A doctor would review this information and decide whether their admission was appropriate for the ward. Care plans included goals to work towards to be ready for discharge.
- Between January 2018 and 31 December 2018, the provider reported that bed occupancy was 78%. Admissions were rarely delayed as there was usually a bed available.
- Patients were only moved between wards or hospitals for clinical reasons. For example, if the patient had high risk of self-harm and needed to be placed in a safe room.
- Between 1 January 2018 and 31 December 2018, patients stayed on the wards for an average of eighteen days. Staff identified that sometimes discharge might be delayed, to ensure patients had a suitable placement to be transferred to.
- Between 1 January 2018 and 31 December 2018, the service reported no delayed discharges. Patient discharges were planned, and the service ensured that they transferred care with copies of notes.

The facilities promote recovery, comfort, dignity and confidentiality

- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Springfield ward displayed inspirational quotes and pictures on the ward.
- Patients had their own bedrooms with en-suite and could personalise their bedrooms if they wished.
- There were quiet spaces on each ward where patients could go, and the hospital had an allocated room where patients could meet visitors.
- Patients were offered a choice of food and could access hot drinks and snacks.
- Patients had access to an outside space shared between Chelmer and Springfield wards.
- Patients could make a phone call in private.
- Staff had displayed information about mental and physical health on the ward.
- Staff searched patients in a separate room with privacy screens to protect their dignity.
- Patients had somewhere to store their personal belongings.
- Staff and patients had access to a full range of rooms to meet their requirements.

Patients' engagement with the wider community

- Staff ensured patients maintained contact with the wider community. Staff facilitated walks in the local area.
- Patients had access to volunteering opportunities, running a café and helping the local farm shop.
- Staff supported and encouraged patients to maintain contact with their families. Family members were invited to meetings and could, when appropriate visit the patient on the ward.

Meeting the needs of all people who use the service

- The service was not accessible to all due to the layout of the building. Patients with limited mobility could not access bedrooms located on the first floor of Chelmer ward as there was no lift. Staff could admit patients with reduced mobility to Danbury ward instead where there was a lift and bedrooms were accessible.
- Staff sought accessible ways to support patients with communication needs, and cultural support. Staff could access information in accessible formats or use an interpretation or signing service if needed. An independent advocate and a chaplain service visited the ward each week to support patient needs.

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

Requires improvement



- Staff had displayed information about different types of treatment, local services, patient rights and how to complain on boards around the wards.
- The service met patients' dietary requirements and gave people a choice of food options. A dietician worked with patients who needed extra support with nutrition such as those with eating disorders.

Listening to and learning from concerns and complaints

- The service treated concerns and complaints seriously. Managers conducted thorough investigations and shared lessons learned via staff meetings and fed back to patients.
- The service gave patients information about the complaint's procedure as part of their welcome pack.
- Staff knew how to handle complaints and kept records of both formal and informal complaints. Staff protected complainants from discrimination.
- Staff discussed complaints monthly at the lessons learned meetings with the multidisciplinary team. We reviewed team meeting minutes for the three months prior to the inspection and saw evidence that managers shared this information.
- The wards had received 13 complaints between 1 January 2018 and 31 December 2018. Managers investigated these complaints and upheld six. Managers responded appropriately to remedy any issues raised in the complaints.
- The provider sought general feedback from patients' relatives through a tablet computer on the reception desk, this was new at the time of the inspection, so the provider had no data.

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

Requires improvement



Leadership

- Managers told us they received the right support from those above them.
- Managers had a good understanding of the services they managed and could explain how staff were improving the service to provide good care.

- Staff were positive about the support offered to them by the people in leadership positions in the hospital.
- Senior managers from the hospital and regional team were visible, visited the wards and were open to feedback to staff.
- Managers had access to leadership development opportunities and junior staff could access leadership training.

Vision and strategy

- The service had a vision for what it wanted to achieve, and staff were aware of what this was. Managers linked the organisation's visions and values to staff appraisals.
- Managers had communicated the vision and values to staff at the service through emails and posters.
- Managers gave staff an opportunity to develop the strategy for the service through staff representatives who attended regular governance meetings.
- Staff could explain how they were working towards delivering high quality care and could not identify occasions when budgets had compromise care.

Culture

- Staff felt respected, supported and valued and were positive about working within the hospital.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Staff felt able to raise concerns or whistle-blow without fear of retribution. Staff knew the whistleblowing process.
- The provider had recently appointed four new staff representatives who would attend meetings with senior staff and feedback staff concerns and ideas.
- The provider reported that they had not had to deal with poor staff performance. Managers dealt with any difficulties within teams appropriately, however we found some issues with staff performance related to prescribing. Managers tracked staff sickness and absence which was low at 3.5% for the hospital. Staff could access an occupational health service.
- Staff appraisals included conversations about how staff could be supported to progress in their careers.
- The provider recognised staff success within the service through a national awards programme and a local employee of the month award.

Governance

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

Requires improvement 

- The provider's governance system was not robust enough to ensure the safe care and treatment of patients. Managers had not identified gaps in ligature audits and where staff had not acted on medicines audits. Managers kept a list of planned environmental improvements for the hospital. Environmental audits had not identified that some of the safer rooms on the ward had ligature anchor points. Managers had not acted on performance issues highlighted by Mental health Act audits.
- Meetings for ward staff had a clear structure and covered incidents, complaints and safeguarding concerns.
- Managers completed thorough recruitment checks for new permanent staff, however some agency profiles lacked detail on their experience.
- Staff at all levels met regularly at team meetings, handovers, and governance meetings. There was a clear structure for what should be discussed at these meetings and essential information such as learning from incidents and complaints was included. Staff were aware of procedures for working with other teams within the organisation.
- Staff on Chelmer ward had not implemented all learning identified from pharmacy audits which had picked up on administration errors and prescribing errors. These had not been resolved.
- Staff participated in clinical audits including a monthly quality walk round. Staff understood the process for working with other teams within the provider and external to the organisation to meet the needs of their patients.

Management of risk, issues and performance

- The provider had sufficient oversight of the risks on the site, however there was insufficient oversight of pharmacy and Mental Health Act audits.
- Staff were able to add concerns to the risk register and ward staff could escalate concerns to the ward manager if required. At the time of the inspection we found there were gaps in the risk register relating to ligatures.
- The services had plans for emergencies, such as IT failure.
- Staff files showed that managers addressed performance and absence issues with staff appropriately.

Information management

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- Staff including agency staff, had access to all the electronic systems they needed, such as patient notes and incident reporting, and were able to locate information. Information technology was easily accessed and the infrastructure worked well.
- Information governance systems included confidentiality of patient records.
- Managers had access to an electronic dashboard which showed how their ward was performing according to its performance indicators for staffing and finances.
- Staff made notifications to external bodies such as safeguarding notifications when needed.

Engagement

- The provider gave staff information about their work through staff meetings and opportunities to feedback about the service through staff surveys, forums and staff representatives.
- The provider had an awards scheme for staff who had gone above and beyond for patients and the hospital ran an employee of the month scheme.
- Patients could give feedback in a number of ways to suit their needs, through community meetings and surveys. Managers had access to this feedback and used it to make improvements to the service. Staff involved patients and carers in decisions about changes to the service. Patients were able to apply to be on interview panels for new staff. Staff received information about complaints and feedback in team meetings. Staff could access minutes if they were unable to attend.

Learning, continuous improvement and innovation

- Staff were given opportunities to highlight potential improvements and innovations which could be made to the service. These improvements could be would be discussed in team meetings or through staff side representatives who sat on meetings with senior managers.
- Managers investigated and learned from incidents and met monthly to discuss how they could improve the service following incidents and complaints.
- The service was not participating in research or nationally recognised audits such as Royal College of Psychiatry schizophrenia or psychological therapies

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






Requires improvement



audit. The service was not participating in any peer review schemes or audits such as Royal College of Psychiatry accreditation for inpatient mental health services.

- The provider had a policy for the promotion of equality and diversity in the hospital but did not record any data for monitoring the effectiveness.

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Requires improvement 

Safe and clean environment

- The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff could clearly see all areas of the ward and could utilise a closed circuit television system in bedrooms if patients were high risk. Patients and, where appropriate their family members, gave consent for this system to be used and a lens cap covered the camera when it was not in use to ensure privacy.
- Staff did regular risk assessments and identified all ligature anchor points on the ligature risk assessment. Staff created an action plan to mitigate risks to patients who might try to harm themselves.
- The ward environments allowed staff to observe all parts of the ward using closed circuit television and convex mirrors to mitigate blind spots.
- Staff had access to alarms in order to call for help in case of an incident.
- The ward had a clinic room with all the equipment needed for monitoring patients' physical health and resuscitation equipment for emergencies. Staff maintained equipment and kept it clean.
- The ward consisted of two floors which did not comply with standards set out by the Department of Health on mixed sex accommodation. Due to both male and female patients being accommodated on both floors.
- Staff had access to hand washing facilities and hand gel and followed infection control principles.

Safe staffing

- The service did not have enough nursing staff to keep people safe from avoidable harm. The ward had a staffing establishment of 9 WTE nurses and 23 WTE healthcare assistants with 0.7 WTE nurse vacancies and 5.5 WTE healthcare assistant vacancies. The number of staff available did not meet service's minimum requirements and high numbers of shifts were covered by agency staff. We reviewed staffing rotas for one month and found 11 occasions where there were fewer than two nurses or three healthcare assistants on shift. Minimum staffing numbers were set by service line managers and they reviewed them monthly or when there was an incident. Staffing levels were not sufficient to carry out physical interventions and ensure that patients had one to one time with their named nurse. We saw evidence in clinical governance meeting minutes that low staffing levels were linked to incidents however, the provider had not increased the minimum staff numbers.
- A qualified nurse was present on the wards at all times.
- Managers discussed staffing levels at the morning 'flash' meeting each day and had the authority to bring in additional staff if they needed to account for case mix. Managers prioritised use of regular staff where possible and booked agency staff in block bookings. When managers booked agency staff, they booked those who were familiar with the patients on the ward and ensured they had a suitable induction. Short staffing rarely resulted in staff cancelling escorted leave or ward activities. However, when incidents occurred patients and staff told us there were not always enough staff to respond.
- Medical staff provided cover 24 hours a day 7 days a week through the on-call doctor rota.

Child and adolescent mental health wards

- Managers had not made sure that all staff had the skills needed to provide high-quality care. We reviewed mandatory training records for all staff on the ward and found nine out of 75 training topics had compliance rates below the provider's target of 75%. Training topics essential for staff to do their jobs effectively, such as observation practice and working with young people, had compliance rates of 50%.

Assessing and managing risk to patients and staff

- Staff completed and updated risk assessments using a recognised assessment tool for each patient and used these to understand and manage risks individually. Staff received advance information from a central referrals team prior to the patient arriving. We reviewed six patient records, and all showed evidence that staff had completed an initial assessment during admission and updated this risk assessment regularly.
- Staff followed the provider's policy for the use of observations and completed the paperwork appropriately. Staff searched patients and their bedrooms according to the provider's procedures.
- Staff applied blanket restrictions on patients' freedom only when justified. Informal patients could leave at will.
- Staff discussed changing risks at handovers held twice daily and increased levels of observation if necessary. The multidisciplinary team reviewed risk assessments twice a week at the ward round and they invited patients to these discussions.
- During the period of 1 July 2018 and 31 December 2018 there were 27 episodes of restraint on the ward. These were related to different patients. The wards did not use prone restraint. Staff minimised their use of restrictive interventions and followed best practice when restricting a patient. Staff did not use rapid tranquilisation or seclusion. We observed one episode of restraint during the inspection which staff conducted in line with their training and respected patient dignity.

Safeguarding

- Staff knew how to identify abuse and made reports to the local authority. The team had a social worker who supported the safeguarding process by reviewing and following up any referrals made to the local authority. Staff were aware of the procedure for referrals and all wards displayed posters on the referral process.
- Training compliance with safeguarding was 85%. The training was for children and vulnerable adults and was

provided by an e-learning module. The provider was in the process of arranging face to face level two safeguarding training to improve the quality of this training.

- We reviewed two safeguarding concerns raised by the provider and found that staff had followed procedures to keep patients safe but had not kept clear records for one of the concerns.
- Senior staff reviewed safeguarding cases and concerns each month at the lessons learned meeting. The social worker provided feedback at this meeting on the actions taken by the local authority and any protective measures in place.
- The ward had safe procedures for when children visited patients at the service. There was an allocated room for patients to meet with visitors.

Staff access to essential information

- Staff kept detailed records of patients' care and treatment on a secure electronic system.
- Records were clear, up-to-date and easily available to all staff providing care, including agency staff.
- The service had a contingency plan should the electronic system fail. The ward manager kept paper backup records.

Medicines management

- Staff followed best practice when storing, giving, and recording medicines. We checked the ward's medicine storage procedures and 13 prescription charts during the inspection. Prescribers of medicine followed guidance and staff kept contemporaneous records when they gave patients medicines.
- Patients received information about the medicines they were taking. Staff could offer verbal or written advice in the form of leaflets. Patients told us that they felt they understood their medicines and that staff would review any concerns they had.
- Staff regularly reviewed the effects of medications on each patient's physical health through regular ward rounds.
- A local pharmacy managed the medicine stock for the ward. Staff could order any medicines needed and they supplied this promptly. The pharmacist sent managers a monthly report on the ward's compliance to the service's medicines management policy and staff on the child and adolescent mental health ward acted on issues identified.

Child and adolescent mental health wards

Track record on safety

- Incident numbers were high on the ward, there were 35 reports made in February 2018. The service had recorded five serious incidents between 1 January 2018 and 31 December 2018 on the child and adolescent mental health wards. One incident related to staff on patient abuse and the staff member was no longer working with the provider, two incidents related to patient on patient abuse, one incident related to a patient absconding from accident and emergency at the local hospital and one related to a patient becoming unwell at a local general hospital.
- The ward manager and staff were able to highlight recent incidents and actions taken.

Reporting incidents and learning from when things go wrong

- Staff recognised incidents and reported them appropriately using the electronic system. All staff, including agency staff had access to this system.
- Managers arranged for staff to debrief following a serious incident.
- Managers investigated incidents and shared lessons learned with the whole team and the wider service. Senior staff met monthly to discuss incidents and develop lessons learned. We observed one of these meetings during the inspection. Staff kept minutes of the meeting and followed a standing agenda. Staff followed up all actions from previous sessions.
- Staff received monthly bulletins on safety and incidents from the regional team and managers discussed lessons learned in team meetings and staff supervisions. The ward manager was able to identify an example of how they had escalated learning from an incident and shared this within the Priory group. Staff gave examples of how practice had changed as a result of incident reporting.
- Staff understood duty of candour, they were open and transparent when things went wrong. Managers wrote to patients and their families to apologise when an incident occurred.

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

Good 

Assessment of needs and planning of care

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans and updated them when needed.
- During the inspection we reviewed six patient records. All were holistic, personalised and recovery orientated.
- Staff held a care planning meeting with patients when they admitted them.
- A referrals team gathered information on the patient's personal and family history prior to admission and ensured that staff had this when assessing patient needs.
- During the inspection we did not see staff use technology to support patients.

Best practice in treatment and care

- Staff provided treatments and care for patients based on national guidance and best practice. Patients had access to psychological therapies such as dialectical behavioural therapy, cognitive behavioural therapy and drama therapy. Staff offered therapies as part of a group and on a one to one basis dependent on need.
- Staff used recognised rating scales such as Health of the Nation Outcome Scale and Health of the Nation Outcome Scale for Children and Adolescents to measure outcomes.
- Staff supported patients with their physical health and encouraged them to live healthier lives with walks and healthy eating advice.
- Staff participated in clinical audit, benchmarking and quality improvement initiatives. The ward manager had access to data showing how their ward was performing against others in the hospital.

Skilled staff to deliver care

- The team included staff from a range of disciplines including doctors, nurses, occupational therapist, clinical psychologists, social workers, dieticians and healthcare assistants.
- Managers told us they had difficulty booking some staff on training as the provider held training sessions at

Child and adolescent mental health wards

other hospitals within the Priory group. The service was working to resolve this by training local staff to train others in topics including safeguarding and the management of violence and aggression.

- Managers supported staff with annual appraisals and monthly supervision and ensured staff received an appropriate induction. The percentage of staff that had an appraisal in the last 12 months was 99%. The percentage of staff that had had clinical supervision regularly was 90%.
- Managers ensured that staff had regular team meetings and kept minutes so that staff who could not attend received updates.
- The provider identified staff learning needs and gave staff opportunities to update and further develop their skills, through continuing professional development sessions and courses offered through the provider's online training system. The hospital was currently training four healthcare assistants to become nurses.
- Permanent staff were experienced and qualified to meet the needs of the patient group.
- Managers ensured that agency staff had appropriate training to work on the ward. However, of the 12 agency profiles we reviewed none had details of the relevant experience the staff member had working with this patient group.
- The service reported they had not had to suspend or performance manage any permanent staff in the last 12 months but one agency member of staff was no longer working at the hospital due to an incident.

Multi-disciplinary and inter-agency team work

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The multidisciplinary team included social workers, occupational therapy, nurses, psychologists, doctors and therapists.
- Staff from a range of disciplines would attend a morning 'flash' meeting where staff could hand over concerns to each other and agree actions. Human resources attended this meeting to help co-ordinate staffing needs but were not involved in clinical discussions about patients. A Mental Health Act administrator attended the meeting and identified patients who may need their rights reviewed under the Mental Health Act.

- Staff from each discipline attended ward rounds and lessons learned meetings. We observed four meetings and saw that staff involved collaborated to keep patients safe and aid their recovery.
- Staff held twice daily handover meetings where they discussed patients' needs for the day and any changes which had occurred.
- The hospital had good links with the local authority. A social worker took the lead in liaising with the local authority on matters of safeguarding and patient needs.

Adherence to the MHA and the MHA Code of Practice

- Staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and when this applied to children. Staff had access to Mental Health Act administrative support, available on site three days per week
- Attendance at mandatory training was low, we checked mandatory training records and found 70% of staff had attended annual training on the Mental Health Act.
- Staff had access to the provider's policies surrounding the Mental Health Act and the Code of Practice.
- Staff explained to patients their rights under the Mental Health Act when required and whenever there were changes to their circumstance. Staff ensured that patients had access to section 17 leave. Staff requested an opinion from a second opinion appointed doctor when necessary. Staff stored copies of patients' detention papers and associated records correctly.
- An independent mental health advocate visited the ward on a weekly basis to support patients with their rights and concerns.
- The Mental Health Act administrator completed a monthly audit of Mental Health Act paperwork to ensure that the ward was meeting the legal requirements of the act. We reviewed the paperwork for two patients detained under the Mental Health Act, which was present and complete.
- The service displayed notices to tell informal patients that they were free to leave the ward if they wished.

Good practice in applying the MCA

- Seventy five percent of staff had training in the Mental Capacity Act and staff we spoke with had a good understanding of the Mental Capacity Act and when it applied to their patient group.

Child and adolescent mental health wards

- There were no Deprivation of Liberty Safeguards applications in the last 12 months.
- The provider had a policy on the Mental Capacity Act and Deprivation of Liberty safeguards and staff had access to it.
- Staff supported patients to make decisions on their care for themselves. They understood when to apply the Mental Capacity Act 2005 in the case of young people and assessed and recorded capacity clearly. Staff assessed patients' capacity to consent to their own treatment if they were under 16 using the Gillick competency framework. We reviewed the records of six patients, all showed evidence that staff had assessed the patient's capacity and there was informed consent to treatment.
- Staff received annual training on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and had access to administrative advice.

Are child and adolescent mental health wards caring?

Good



Kindness, privacy, dignity, respect, compassion and support

- Staff attitudes demonstrated that they were discreet, respectful and responsive.
- Carers were generally positive about the way staff treated their family members and said they were respectful.
- Staff supported patient's individual needs by offering them ways to record their journeys through scrap booking and murals. Staff understood the individual needs of patients including their cultural, social and religious needs.
- Staff supported patients to understand their care and their condition.
- Staff supported patients to access services outside the hospital when appropriate.
- Staff said they were comfortable raising concerns about disrespectful or abusive behaviour.
- Staff took steps to maintain confidentiality of patients.

- The provider had improved patient's dignity when they searched them for contraband items by having a private room near the entrance of the hospital with privacy screens.

Involvement in care

- Staff orientated patients and gave them information about the service when they admitted them to the wards.
- Patients said they were involved in decisions about their care and treatment. Staff completed risk assessments alongside patients. Staff communicated with patients about their care and treatment, they held ward round meetings which patients could to attend and be involved in the decision making. The wards also held a weekly community meeting, enabling patients to give feedback and to voice concerns and issues.
- Family members told us that they were involved in their relative's care when it was appropriate, and staff invited them to attend meetings.
- Staff ensured patients had copies of their care plans. Of the six patient care plans reviewed, we saw that all patients had received a copy.
- Staff supported patients to access advocacy services.
- Staff kept family members involved in the care and treatment of their relative and gave them opportunities to give feedback.

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

Good



Access and discharge

- Between January 2018 and 31 December 2018, the provider reported that bed occupancy was 82%. Admissions were rarely delayed as there was usually a bed available.
- Staff received information about each patient from a central admissions team prior to their arrival. A doctor would review this information, conduct a risk assessment and decide whether their admission was appropriate for the ward.

Child and adolescent mental health wards

- The provider was working on a project alongside NHS England to move patients, where possible, to a service close to their home.
- Family members we spoke with said staff were helpful during the discharge process and the provider's aftercare was supportive.
- Between 1 January 2018 and 31 December 2018 patients stayed on the ward for an average of 52 days.
- Patients were only moved between hospitals if they needed to for clinical reasons.
- Between 1 January 2018 and 31 December 2018, the service reported no delayed discharges. Patient discharges were planned, and the service ensured that they transferred care with copies of notes.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a lounge on the ward, however patients could not access it as the air conditioning unit was broken and the provider needed to complete remedial works for them to be safe. The provider was aware of this issue and had arranged a replacement to be fitted.
- Staff offered patients opportunities to record their journeys and support their recovery through scrap booking activities, theatrical make up sessions and mural paintings on the ward walls, created by patients. Patients we spoke with were positive about these activities and said they helped their recovery.
- The design, layout, and furnishings of the ward or service supported patients' treatment, privacy and dignity. There were quiet spaces on each ward where patient could go and the hospital had an allocated room where patients could meet visitors.
- Patients had their own bedrooms with en-suite and could personalise their bedrooms if they wished. Patients had a safe place they could store their belongings.
- Patients were offered a choice of food and could access hot drinks and snacks.
- Patients had access to an outside space, however this was with staff supervision only.
- Patients could make a phone call in private.
- Staff searched patients in a separate room with privacy screens to protect their dignity.
- Staff and patients had access to a range of rooms to meet their needs.

Patients' engagement with the wider community

- Staff supported patients with activities outside the service, such as work, education and family relationships. Family members said they were able to speak to patients when they wanted, and staff invited them to come to regular meetings. At the time of the inspection seven out of the 15 patients on the ward were from out of the area, the service was actively trying to transfer them to their home location to keep contact with their families.
- Patients attended regular education classes at the service. Staff facilitated students to stay on at the school after they turned 16 to take resits of their exams if needed.
- Patients had access to volunteering opportunities, such as helping a horse sanctuary.
- Staff supported and encouraged patients to maintain contact with their families. Family members were invited to meetings and could, when appropriate visit the patient on the ward.

Meeting the needs of all people who use the service

- The service was not accessible to all due to the ward being located on the first floor of the building.
- Staff helped patients with communication, advocacy and cultural support. Staff could access information in accessible formats or use an interpretation or signing service if needed. An independent advocate and a chaplain service visited the ward each week to support patient needs.
- Staff had displayed information about different types of treatment, local services, patient rights and how to complain on boards around the wards.
- The service met patients' dietary requirements and gave people a choice of food options. However, two patients told us that portions were small and could be improved.

Listening to and learning from concerns and complaints

- The service treated concerns and complaints seriously. Managers conducted thorough investigations and we saw evidence of lessons learned in investigation reports. Managers discussed complaints monthly at the lessons learned meetings with the multidisciplinary team and managers fed back to patients.
- Staff knew how to handle both formal and informal complaints and protected patients from victimisation when they made a complaint.

Child and adolescent mental health wards

- The provider gave patients information about the complaint's procedure by the service as part of their welcome pack.
- The ward received five formal complaints between 1 January 2018 and 31 December 2018, two of which were upheld. We reviewed three of these complaints in detail and managers investigated all complaints individually. Two complaints were partially upheld. Issues raised in these complaints related to: staff attitudes, physical healthcare, access to outside areas and inappropriate treatment. All complainants received a response from the hospital director. All three complaints showed evidence of lessons learned and actions to follow up.
- The provider sought general feedback from patients' relatives and verbally at meetings and through a tablet computer on the reception desk. This tablet was new at the time of the inspection, so the provider did not have any data.

Are child and adolescent mental health wards well-led?

Requires improvement 

Leadership

- Managers told us they received the right support from those above them.
- Managers had a good understanding of the services they managed and could explain how staff were improving the service to provide good care.
- Staff were positive about the support offered to them by the people in leadership positions in the hospital.
- Senior managers from the hospital and regional team were visible, visited the wards and were open to feedback to staff.
- Managers had access to leadership development opportunities and junior staff could access leadership training.

Vision and strategy

- The service had a vision for what it wanted to achieve, and staff were aware of what this was. Managers linked the organisation's visions and values to staff appraisals.
- Managers had communicated the vision and values to staff at the service through emails and posters.

- Managers gave staff an opportunity to develop the strategy for the service through staff representatives who attended governance meetings.
- Staff could explain how they were working towards delivering high quality care and could not identify occasions when budgets had compromise care.

Culture

- Staff felt respected, supported and valued and were positive about working within the hospital.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Staff felt able to raise concerns or whistle-blow without fear of retribution. Staff knew the whistleblowing process.
- The provider had recently appointed four new staff representatives who would attend meetings with senior staff and feedback staff concerns and ideas.
- Managers dealt with any difficulties within teams appropriately.
- Managers tracked staff sickness and absence which was low at 3.5% for the hospital. Staff could access an occupational health service.
- Staff appraisals included conversations about how staff could be supported to progress in their careers.
- The provider recognised staff success within the service through a national awards programme and a local employee of the month award. Two therapists from the ward had been nominated for a national recognition award.

Governance

- The provider's governance system was not robust enough to ensure the safe care and treatment of patients. Senior staff had identified that a high rate of incidents on the ward was linked to low staffing levels but the provider had not taken action to resolve this.
- Managers completed thorough recruitment checks for new permanent staff, however some agency profiles lacked detail on their experience.
- Staff at all levels met regularly at team meetings, handovers, and governance meetings. There was a clear structure for what should be discussed at these meetings and essential information such as learning from incidents and complaints was included.

Child and adolescent mental health wards

- Staff files showed that managers addressed performance and absence issues with staff appropriately.
- Staff participated in clinical audits including a monthly quality walk round. The pharmacist sent monthly audits detailing staff compliance to the medicines management policy and the mental health act administrator audited compliance against the Mental Health Act 1983. Staff understood the process for working with other teams within the provider and external to the organisation to meet the needs of their patients.
- Staff understood the arrangements for working with other teams in the organisation.

Management of risk, issues and performance

- The provider had sufficient oversight of the risks on the site.
- Managers had access to electronic data via a dashboard which they could use to monitor how their ward was performing.
- Staff were able to add concerns to the risk register and ward staff could escalate concerns to the ward manager if required. We found some gaps in the risk register during the inspection, however managers had sufficient oversight and responded to concerns appropriately.
- The services had plans for emergencies, such as IT failure.
- Staff files showed that managers addressed performance and absence issues with staff appropriately.

Information management

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- Staff including agency staff, had access to all the electronic systems they needed, such as patient notes and incident reporting, and were able to locate information. Information technology was easily accessed and the infrastructure worked well.
- Information governance systems included confidentiality of patient records.
- Managers had access to an electronic dashboard which showed how their ward was performing according to its performance indicators for staffing and finances.
- Staff made notifications to external bodies such as safeguarding notifications when needed.

Engagement

- The provider gave staff information about their work through staff meetings and opportunities to feedback about the service through staff surveys, forums and staff representatives.
- The provider had an awards scheme for staff who had gone above and beyond for patients and the hospital ran an employee of the month scheme.
- Patients could give feedback in a number of ways to suit their needs, through community meetings and surveys. Managers had access to this feedback and used it to make improvements to the service. Staff involved patients and carers in decisions about changes to the service, patients were able to apply to be on interview panels for new staff. Staff received information about complaints and feedback received in team meetings, staff could access minutes if they were unable to attend.






Learning, continuous improvement and innovation

- Staff were given opportunities to highlight potential improvements and innovations which could be made to the service. These improvements could be made in meetings or through staff side representatives who sat on meetings with senior managers.
- Managers investigated and learned from incidents and met monthly to discuss how they could improve the service following incidents and complaints.
- All communal areas and bedrooms on the ward had a closed-circuit television system that an external provider remotely monitored to support high-risk patients. Staff used bedroom cameras with the express consent of the patient, who was aware they were being monitored, and trained medical staff reviewed the footage, calling the ward staff if they were concerned about a patient. We reviewed the provider's policy for this system and found that video footage was stored and transmitted securely, and the provider was transparent with patients about its use. The organisation had created leaflets to help patients to understand the process for use of these cameras and their rights around consent.
- The service was not participating in research or nationally recognised audits such as Royal College of Psychiatry psychological therapies audit. The service was not participating in any peer review schemes such as Royal College of Psychiatry network for inpatient children and adolescent mental health services.

Child and adolescent mental health wards

- The provider had a policy for the promotion of equality and diversity in the hospital but did not record any data for monitoring the effectiveness.

Substance misuse services

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

Are substance misuse services safe?

Requires improvement 

Safe and clean environment

- The provider had not ensured that all ward environments were safe. On Chelmer ward the provider had bedrooms which they identified as safer rooms, designed to reduce risk of ligatures. We found fittings in these rooms were loose and patients at risk could use them as a ligature point. On Chelmer ward we found potential ligature anchor points in the stairwells which staff had not identified. Staff had identified other ligature risks but not sufficiently mitigated them. Staff on Chelmer had identified some areas as lower risk due to high staff traffic, however we found these areas to have low levels of staff traffic.
- On the lodge staff had identified potential risks in the environment and had assessed patients individually. If patients were assessed as high risk of self harm then staff would observe them according to hospital policy.
- The ward environments allowed staff to observe all parts of the ward using convex mirrors to mitigate blind spots.
- Staff had access to alarms to call for help in case of an incident.
- Chelmer ward had a fully equipped clinic room with all the equipment needed to monitor patients' physical health. Staff maintained equipment and kept it clean.
- The wards were clean, and the furniture was well maintained.
- Staff had access to handwashing facilities and hand gel and followed infection control principles.

Safe staffing

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Chelmer ward had a staffing establishment of 6.4 WTE nurses and 16.8 WTE healthcare assistants with 1.29 WTE nurse vacancies and 2.84 WTE healthcare assistant vacancies. Staff who worked at The Lodge came from Chelmer ward. Staffing levels were sufficient to carry out physical interventions and ensure that patients had one to one time with their named nurse. Medical staff provided 24-hour cover through an on-call doctor rota, a doctor could attend the wards promptly if there was an emergency.
- Managers discussed staffing levels at the morning 'flash' meeting each day and had the authority to bring in additional staff if they needed to. Managers prioritised use of regular staff where possible and booked agency staff in block bookings. When managers booked agency staff, they booked those who were familiar with the patients on the ward and ensured they had a suitable induction.
- Managers could increase staffing requirements to meet patient needs.
- Managers had not ensured that staff had the skills needed to provide high-quality care. We reviewed mandatory training records for all staff on the wards and found three out of 78 training topics had compliance rates below 60%.

Assessing and managing risk to patients and staff

- Staff completed and updated risk assessments for each patient using a recognised tool and used these to understand and manage specific risks for individuals. We reviewed three patient records and found all of them

Substance misuse services

had a completed risk assessment from admission. Staff identified and responded to changing risks by updating risk assessments on a regular basis and when there had been an incident.

- Staff did not use restrictive interventions for patients undergoing treatment for addictions and used de-escalation techniques if required.
- Staff followed the provider's policy for the use of observations and completed the paperwork appropriately. Staff searched patients and their bedrooms according to the provider's procedures.
- Staff applied blanket restrictions on patients' freedom only when justified.
- During the period of 1 July 2018 and 31 December 2018 there were no episodes of restraint on the for substance misuse patients. The wards did not use prone restraint or long-term segregation. Staff minimised their use of restrictive interventions through de-escalation techniques. Staff did not use rapid tranquilisation or seclusion.

Safeguarding

- Staff were aware of the referrals procedure for safeguarding and posters were displayed on all wards. Staff were able to give examples of how they would identify abuse and safeguard patients.
- Training compliance with the provider's e-learning safeguarding training was 94%.
- The team had a social worker who supported the safeguarding process by reviewing and following up any referrals made to the local authority.
- Senior staff reviewed safeguarding cases and concerns each month at the lessons learned meeting. The social worker provided feedback at this meeting on the actions taken by the local authority and any protective measures in place.
- The wards had safe procedures for when children visited patients. There was an allocated room for patients to meet with visitors.

Staff access to essential information

- Staff kept detailed records of patients' care and treatment on a secure electronic system.
- Patient records were clear, up-to-date and easily available to all staff providing care, including agency staff.

- The service had a contingency plan should the electronic system fail. The ward manager kept paper backup records securely.

Medicines management

- Staff did not follow best practice when storing, giving and recording medicines. We checked the ward's medicine storage procedures and 11 prescription charts during the inspection. We found prescribing errors in three prescription charts. The pharmacist had highlighted some errors, but staff on Chelmer ward had not resolved these errors. On Chelmer ward doctors had not reviewed one patient's medicine after they had completed detoxification.
- Staff had numbered some prescription charts on Chelmer incorrectly which meant they could not be sure if other staff had supplied the medication to the patient.
- Patients received information about the medicines they were taking. Staff could offer verbal or written advice in the form of leaflets. Patients told us that they understood their medicines and staff would review any concerns they had.
- Staff regularly reviewed the effects of medications on each patient's physical health through regular ward rounds and blood monitoring where appropriate.
- A local pharmacy managed the medicine stock for the wards. Staff could order any medicines needed and the pharmacy supplied it promptly.

Track record on safety

- Between 12 February 2018 and 27 December 2018 there had been no serious incidents on the substance misuse wards at the hospital.
- Managers and staff were able to give examples of recent serious incidents from other wards and lessons learned through those incidents.

Reporting incidents and learning from when things go wrong

- Staff had not identified all types of incidents for example medicines errors. Managers held a monthly 'lessons learned' meeting to discuss recent incidents and what they could learn from them. We reviewed ward meeting minutes and found staff discussed lessons learned regularly and this was a standing agenda item. All staff, including agency staff had access to the electronic reporting system.

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- Managers arranged for staff to debrief following a serious incident with a psychologist and a senior manager.
- Staff understood duty of candour, they were open and transparent when things went wrong. Managers wrote to patients and their families to apologise when an incident occurred.
- Managers investigated incidents that staff had reported, and shared lessons learned with the whole team and the wider service. Managers sent information from the provider about incidents which had happened nationally through ward meetings. Staff gave examples of how practice had changed as a result of incident reporting.

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

Good



Assessment of needs and planning of care

- Staff assessed the physical and mental health of all patients after admission. During the inspection we reviewed 6 patient records, in one record, staff had copied the patient's assessment from another patient's record.
- Three care plans for patients did not fully meet their needs as staff had not assessed their alcohol consumption fully.

Best practice in treatment and care

- Staff provided treatments and care for patients based on national guidance and best practice and ensured that patients had good access to substance misuse specialists. Staff met patients' needs for food and drink.
- Patients had access to psychological therapies such as dialectical behavioural therapy, emotional regulation and cognitive behavioural therapy.
- Staff supported patients to live healthier lives by organising walks in the local areas, giving advice on healthy eating and smoking cessation.
- Staff used the Clinical Institute Withdrawal Assessment for alcohol scale to monitor patients' withdrawal. Patients had access to a 12-step therapy programme to support their recovery.

Skilled staff to deliver care

- Managers supported staff with annual appraisals and monthly supervision and ensured staff received an appropriate induction. The percentage of staff that had had an appraisal in the last 12 months was 100%. The percentage of staff that had had clinical supervision regularly was 92%. However, in the staff records we reviewed on Chelmer ward, supervision records lacked detail and managers had not given actions a timeframe for completion or follow up. Managers ensured that staff had regular team meetings and kept minutes so that staff who could not attend received updates.
- The provider identified staff learning needs and gave staff opportunities to update and further develop their skills, through continuing professional development sessions and courses offered through the provider's online training system. This included specialist training for their roles.
- Permanent staff were experienced and qualified to meet the needs of the patient group.
- Managers ensured that agency staff had appropriate training to work on the ward. However, of the 12 agency profiles we reviewed, none included details of the relevant work experience the staff member had for the patient group.
- The service reported they had not had to suspend, or performance manage any staff in the last 12 months.

Multi-disciplinary and inter-agency team work

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The multidisciplinary team included social workers, occupational therapy, nurses, psychologists, doctors, dieticians and therapists.
- Staff from a range of disciplines would attend a morning 'flash' meeting where staff could hand over concerns to each other and agree actions. Human resources team members attended this meeting to help co-ordinate staffing needs but did not join in the clinical discussions about patient needs. A Mental Health Act administrator attended the meeting and identified patients who may need their rights reviewed under the Mental Health Act.
- Staff from each discipline attended weekly meetings, ward rounds and lessons learned meetings. We observed four meetings and saw that staff involved, collaborated to keep patients safe and aid their recovery.

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- Staff held twice daily handover meetings where they discussed patients' needs for the day and any changes which had occurred.
- The hospital had good links with the local authority. A social worker took the lead in liaising with the local authority on matters of safeguarding and patient needs.

Adherence to the MHA and the MHA Code of Practice

- Nursing staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- The substance misuse wards did not routinely detain patients under the Mental Health act.
- We reviewed staff training records, 70% of staff had attended annual training on the Mental Health Act and administrative support was available on site three days per week.
- Staff had access to the provider's policies surrounding the Mental Health Act and the code of practice.

Good practice in applying the MCA

- Seventy percent of staff had training in the Mental Capacity Act and staff we spoke with had a good understanding of the Act.
- There were no Deprivation of Liberty Safeguards applications in the last 12 months.
- The provider had a policy on the Mental Capacity Act and Deprivation of Liberty safeguards and staff had access to it.
- Staff supported patients to make decisions on their care for themselves. They understood when to apply the Mental Capacity Act 2005 and assessed and recorded capacity clearly. We reviewed the records of six patients, all showed evidence that staff had assessed the patient's capacity and there was informed consent to treatment.
- Staff received annual training on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and had access to administrative advice.
- The provider monitored compliance with Mental Capacity Act policy through audits.

Are substance misuse services caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

- Staff treated patients with compassion and kindness and respected their privacy and dignity. Patients who were in hospital for substance misuse could lock their bedroom doors. Staff attitudes demonstrated that they were discreet, respectful and responsive.
- Patients we spoke with told us that staff treated them with dignity and respect and were always around when they needed them.
- Family members were generally positive about the way staff treated their relatives and said they were respectful.
- Staff supported patients' individual needs, assessing their, cultural mobility and language needs on arrival at the service. Staff supported patients to understand their care and their condition.
- Staff supported patients to access services outside the hospital when appropriate.
- Staff said they were comfortable raising concerns about disrespectful or abusive behaviour.
- Staff took steps to maintain confidentiality of patients.
- The provider had improved preserving patient dignity when staff conducted searches for contraband items, by having a private room near the entrance of the hospital with privacy screens.

Involvement in care

- Staff orientated patients and gave them information about the service when they admitted them to the wards.
- Patients said they were involved in decisions about their care and treatment. Staff completed risk assessments alongside patients. Staff communicated with patients about their care and treatment, they held ward round meetings which patients could to attend and be involved in the decision making.
- The wards also held a weekly community meeting, enabling patients to give feedback and to voice concerns and issues.

Substance misuse services

- Family members told us that they were involved in their relative's care when it was appropriate, and staff invited them to attend meetings.
- Staff supported patients to access advocacy services.
- Staff kept family members involved in the care and treatment of their relative and gave them opportunities to give feedback.

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

Good



Access and discharge

- Between January 2018 and 31 December 2018 the provider reported that bed occupancy was 78% and patients stayed on average 18 days. Admissions were rarely delayed as there was usually a bed available.
- Staff received information about each patient from a central admissions team prior to their arrival. A doctor would review this information and decide whether their admission was appropriate for the ward.
- Between 1 January 2018 and 31 December 2018 the service reported no delayed discharges. Patient discharges were planned and the service ensured that they transferred care with copies of notes.
- Patients were only moved during their admission when this was clinically appropriate, for example when they had completed detoxification and were ready to commence rehabilitation.
- However, of the three patient records we reviewed, none had a plan for unexpected discharge.

The facilities promote recovery, comfort, dignity and confidentiality

- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Patients had their own bedrooms with en-suite and could personalise their bedrooms if they wished.
- The hospital had an allocated room where patients could meet visitors.
- Patients were offered a choice of food and could access hot drinks and snacks.
- Patients had access to an outside space.
- Patients could make a phone call in private.

- Staff had displayed information about mental and physical health on the ward.
- Staff searched patients in a separate room with privacy screens to protect their dignity.
- The Lodge offered an environment that was safe and provided patients with accommodation like a home environment.
- Patients had somewhere to store their personal belongings.

Patients' engagement with the wider community

- Staff ensured patients maintained contact with the wider community. Patients undergoing treatment for alcohol addiction were able to access a local alcoholics anonymous group. Staff facilitated walks in the local area. Patients had access to volunteering opportunities, running a café and helping the local farm shop.
- Staff supported and encouraged patients to maintain contact with their families. Family members were invited to meetings and could, when appropriate visit the patient on the ward.

Meeting the needs of all people who use the service

- The service was not accessible to all due to the layout of the building. Patients with limited mobility could not access bedrooms located on the first floor of Chelmer ward as there was no lift. Staff could admit patients with reduced mobility to Danbury ward instead where there was a lift and bedrooms were accessible. The Lodge was fully accessible.
- Staff helped patients with communication, advocacy and cultural support. Staff could access information in accessible formats or use and interpretation or signing service if needed. An independent advocate and a chaplain service visited the ward each week to support patient needs.
- Staff had displayed information about different types of treatment, local services, patient rights and how to complain on boards around the wards.
- The service met patients' dietary requirements and gave people a choice of food options.

Listening to and learning from concerns and complaints

- The service treated concerns and complaints seriously. Managers conducted thorough investigations and shared lessons learned via staff meetings.

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- The service gave patients information about the complaints procedure as part of their welcome pack.
- Staff discussed complaints monthly at the lessons learned meetings with the multidisciplinary team and managers fed back to patients. We reviewed team meeting minutes for the three months prior to the inspection and saw evidence that managers shared this information.
- The wards had received eight complaints between 1 January 2018 and 31 December 2018. Managers investigated these complaints and upheld four, managers responded appropriately to remedy any issues raised in the complaints.
- The provider sought general feedback from patients' relatives through a tablet computer on the reception desk, this was new at the time of the inspection, so the provider had no data.

Are substance misuse services well-led?

Requires improvement 

Leadership

- Managers told us they received the right support from those above them.
- Managers had a good understanding of the services they managed and could explain how staff were improving the service to provide good care.
- Staff were positive about the support offered to them by the people in leadership positions in the hospital.
- Senior managers from the hospital and regional team were visible, visited the wards and were open to feedback to staff.
- Managers had access to leadership development opportunities and junior staff could access leadership training.

Vision and strategy

- The service had a vision for what it wanted to achieve, and staff were aware of what this was. Managers linked the organisation's visions and values to staff appraisals.
- Managers had communicated the vision and values to staff at the service through emails and posters.
- Managers gave staff an opportunity to develop the strategy for the service through staff representatives.

- Staff could explain how they were working towards delivering high quality care and could not identify occasions when budgets had compromised care.

Culture

- Staff felt respected, supported and valued and were positive about working within the hospital.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Staff felt able to raise concerns or whistle-blow without fear of retribution. Staff knew the whistleblowing process.
- The provider had recently appointed four new staff representatives who would attend meetings with senior staff and feedback staff concerns and ideas.
- Managers tracked staff sickness and absence which was low at 3.5% for the hospital. Staff could access an occupational health service.
- Staff appraisals included conversations about how staff could be supported to progress in their careers.

Governance

- The provider's governance system was not robust enough to ensure the safe care and treatment of patients. Managers had not identified gaps in ligature audits on Chelmer and where staff had not acted on medicines audits. Managers kept a list of planned environmental improvements for the hospital. Environmental audits had not identified that some of the safer rooms on the ward had ligature anchor points.
- Managers completed thorough recruitment checks for new permanent staff, however some agency profiles lacked detail on their experience.
- Staff at all levels met regularly at team meetings, handovers, and governance meetings. There was a clear structure for what should be discussed at these meetings and essential information such as learning from incidents and complaints was included.
- Staff on Chelmer ward had not implemented all learning identified from pharmacy audits, but staff on the The Lodge had implemented changes.
- Staff files showed that managers addressed performance and absence issues with staff appropriately.

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- Staff participated in clinical audits including a monthly quality walk round. Staff understood the process for working with other teams within the provider and external to the organisation to meet the needs of their patients.
- The provider had not had to deal with poor staff performance but during the inspection we identified poor staff performance with compliance to medicines audits on Chelmer. Managers dealt with any difficulties within teams appropriately.

Management of risk, issues and performance

- The provider had sufficient oversight of the risks on the site, however there was insufficient oversight of governance audits.
- Staff were able to add concerns to the risk register and ward staff could escalate concerns to the ward manager if required, we found some gaps in the risk register during the inspection, however managers had sufficient oversight and responded to concerns appropriately.
- The services had plans for emergencies, such as IT failure.
- Staff files showed that managers addressed performance and absence issues with staff appropriately.

Information management

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- Staff including agency staff, had access to all the electronic systems they needed, such as patient notes and incident reporting, and were able to locate information. Information technology was easily accessed and the infrastructure worked well.
- Information governance systems included confidentiality of patient records.
- Managers had access to an electronic dashboard which showed how their ward was performing according to its performance indicators for staffing and finances.

- Staff made notifications to external bodies such as safeguarding notifications when needed.

Engagement

- The provider gave staff information about their work through staff meetings and opportunities to feedback about the service through staff surveys, forums and staff representatives.
- The provider had an awards scheme for staff who had gone above and beyond for patients and the hospital ran an employee of the month scheme.
- Patients could give feedback in a number of ways to suit their needs, through community meetings and surveys. Managers had access to this feedback and used it to make improvements to the service. Staff involved patients and carers in decisions about changes to the service. Patients were able to apply to be on interview panels for new staff. Staff received information about complaints and feedback received in team meetings, staff could access minutes if they were unable to attend.

Learning, continuous improvement and innovation

- Staff were given opportunities to highlight potential improvements and innovations which could be made to the service. These improvements could be made in meetings or through staff side representatives who sat on meetings with senior managers.
- Managers investigated and learned from incidents and met monthly to discuss how they could improve the service following incidents and complaints.
- The service was not participating in research or nationally recognised audits such as Royal College of Psychiatry psychological therapies audit. The service was not participating in any accreditation schemes.
- The provider had a policy for the promotion of equality and diversity in the hospital but did not record any data for monitoring the effectiveness.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that the ward environments are safe and well maintained.
- The provider must ensure they take action to ensure that issues highlighted by compliance audits are promptly resolved by staff.
- Staff must ensure that prescriptions for medications comply with the Mental Health Act 1983.
- The provider must ensure a robust system is in place to monitor ligature risk assessments and actions from audits for the service.

Action the provider **SHOULD** take to improve

- The provider should ensure that there are enough staff on the child and adolescent mental health ward to keep young people safe from avoidable harm.

- The provider should ensure that staff on CAMHs ward treat patients with dignity and respect.
- Staff should ensure that all patients receive regular physical health monitoring.
- The provider should ensure that staff on the child and adolescent mental health wards involve patients in decisions about their care.
- The provider should ensure that patients undergoing treatment for substance misuse have plans for unexpected discharge.
- The provider should ensure that they keep records of the relevant work experience of agency staff working in the hospital.
- Managers should ensure that they address issues with staff performance in relation to audits.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose The provider had not ensured that the ligature risk assessment for Chelmer Ward accurately identified or mitigated all risks. The provider had not ensured that prescribing errors were remedied. The provider had not ensured that all patients received physical health monitoring regularly. This was a breach of regulation 12.
Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have appropriate oversight of all environmental risks or processes to follow up on actions from audits. This was a breach of regulation 17