Partnerships in Care Limited

Priory Hospital Burgess Hill

Inspection report

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

Ratings

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

Summary of findings

Overall summary

The Priory Hospital Burgess Hill is an independent hospital which provides inpatient mental health treatment to adults. We undertook an unannounced comprehensive inspection to review the standard of patient care and to check if the service had made the improvements, we told them they must make from the previous inspection.

Our rating of this location went down. We rated it as requires improvement because:

Although we found the hospital had made a number of improvements since our last inspection, there were still a number of outstanding improvements that had not been made. In addition, we identified some additional areas of concern.

- The ward environments were not always safe or well maintained. Bedrooms and ward areas on Michael Shepherd ward had fixed ligature anchor points. The wards were generally in need of refurbishment.
- Staff did not assess and manage risk well. Patient risk assessments were not always reviewed regularly, including after any incident, and patient observations were missed on Edith Cavell ward.
- Vacancy rates remained high for permanent registered nurses.
- Patients reported that their section 17 leave had been cancelled at short notice. Staff did not always document the rationale for the cancellation.
- Patients on Michael Shepherd ward reported the food was not always tasteful.
- Managers did not always ensure all staff had an appraisal.
- The hospital did not actively support patients on the forensic inpatients and secure ward to access opportunities for work and education.
- Governance processes did not always ensure that ward procedures ran smoothly and did not identify issues around lack of coordination between the various systems and processes in place.

However:

- Staff managed medicines safely and followed good practice with respect to safeguarding.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training and supervision.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff were generally kind and supportive. Patients said they felt safe on the wards.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission.
- Staff assessed the physical and mental health of all patients on admission. Staff from different disciplines worked together as a multidisciplinary team to benefit patients.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Requires Improvement 	Our rating of this service went down. We rated it as requires improvement because: Although we found the service largely performed well it did not meet some requirements relating to safe care and governance, meaning we could not give it a rating higher than requires improvement. • The ward environments were not always safe, clean, or well maintained. Bedrooms and ward areas had fixed ligature points. The ward was in need of refurbishment. • Staff did not ensure patients section 17 leave was always taken. When patients section 17 leave was cancelled at short notice, staff did not always document the rationale for the cancellation. Patients and carers reported that patients were not getting enough fresh air. • Patients reported that the food was not always tasteful. • Managers did not ensure all staff had an appraisal. • The service did not actively support patients to access opportunities for work and education. • The governance processes did not always address concerns or mitigate against identified risks. For example, the ligature audit had identified potential ligature points but there was no clear timeframes or action for when these will be addressed. It was not clear how patient feedback were captured and actions taken to address them. However: • The service managed medicines safely and followed good practice with respect to safeguarding. • Staff assessed the physical and mental health of all patients on admission. Staff from different disciplines worked together as a team to benefit patients. • The ward teams included or had access to the full range of specialists required to meet the

Summary of findings

needs of patients. Managers ensured that these staff received training and supervision. The ward staff worked well together as a multidisciplinary team.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

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

Requires Improvement

Our rating of this service went down. We rated it as requires improvement

- Staff did not assess and manage risk well. Patient risk assessments were not always reviewed regularly, including after any incident and patient observations were missed. Vacancy rates remained high for permanent registered nurses.
- The wards were not always well maintained and they looked in need of refurbishment.
- Managers did not ensure all staff had an appraisal.
- The governance processes were not always robust enough to sufficiently identify, remove or reduce risks on the wards. For example, the ligature audits were not always reviewed as planned.

However:

- The ward environments were clean. Staff minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training and supervision. The ward staff worked well together as a multidisciplinary team.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

- Staff treated patients with compassion and kindness. Staff understood the individual needs of patients.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.

Summary of findings

Contents

Summary of this inspection

Background to Priory Hospital Burgess Hill

The Priory Hospital Burgess Hill is a purpose-built hospital providing assessment and treatment in acute and psychiatric intensive care units, as well as low secure services for people with mental health conditions. During the inspection, the hospital had three open wards and three closed. The open wards were:

- Michael Shepherd, a female low secure unit with 16 beds.
- Wendy Orr, a male psychiatric intensive care unit with eight beds.
- Edith Cavell, a male acute service with 16 beds.

At the time of the inspection there were nine patients on Michael Shepherd ward, seven on Edith Cavell ward and four on Wendy Orr ward.

Priory Hospital Burgess Hill was last inspected in May 2021 because of concerning information we had received about patient safety. During that inspection we found a number of areas of concern. Following the inspection, we wrote to the provider and told them that we required them to provide us with assurance that they would make immediate and ongoing improvements under Section 31 of the Health and Social Care Act 2008. The provider responded with an action plan that described how they would address these concerns. In addition, the provider decided to close two hospital wards (the female psychiatric intensive care and female personality disorder wards) in order to ensure they could staff the three remaining wards safely. We reviewed the provider's action plan and felt that the actions the provider told us they were taking provided enough assurance about how they would address the areas of concern around patient safety. However, we issued requirement notices to the provider around staff not being always able to access patients' records and lack of robust governance processes. We also suspended the ratings for the hospital; due to the closure of two wards the ratings were no longer a true reflection of the service provided.

Previously, the hospital was inspected in August 2020. This was an unannounced, focused inspection and we focussed on areas of the key question, are services safe. During the inspection, we identified concerns and issued requirement notices to the provider related to poor recording of patients' section 17 leave, lack of individualised risk management plans for patients, lack of induction for agency staff, poor record keeping for seclusion and post rapid tranquilisation, not having clear processes in place to review prescribing that did not follow national recommendations, Mental Health Act documents (Section 62) not always being completed and lack of substantive staff. Following this inspection, we rated the key question 'are services safe' as requires improvement.

During this inspection visit on 10 and 11 August 2021, we found that the provider had made some improvements, but there was more work to be done around the safety of the ward environment, general maintenance, assessing and managing risks and governance processes.

The hospital last had a comprehensive inspection in April 2019. We rated the service good overall and good in all domains.

The hospital is registered to provide the following regulated activities:

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

The hospital has a manager registered with CQC.

Summary of this inspection

What people who use the service say

People who use the acute and intensive care services were largely positive about their experiences at the hospital. The patients we spoke with reported feeling safe and felt that the staff were kind and polite and took a genuine interest in their care and wellbeing. Patients told us that there were enough staff on the wards and that they had the opportunity to participate in a range of activities. The patients we spoke with told us that the wards were clean, quiet and calm. They also reported that they were able to seek advice and support from staff about their physical health. However, some of the patients told us that they were not given information on admission about their condition, rights and treatment, and did not have a copy of their care plans.

We also received positive feedback from the families we spoke with about the quality of care patients received from staff. Most of the relatives we spoke with felt that patients were safe at the hospital and had the opportunity to participate in activities. They also told us that they believed that staff were supportive, respectful and well trained. However, one family member told us that they were concerned about the care and treatment their relative was receiving at the hospital.

Patients on the forensic inpatient and secure wards were generally positive about the hospital and staff. They told us they felt safe on the wards and most staff were kind and supportive, although some staff members could be rude and inconsiderate. Patients said there were enough staff to talk to, but they could sometimes be very busy. Patients and carers said the medical team were very supportive and were attentive to their needs. They said staff actively involved them in planning their care and they were given copies of their care plans. However, patients told us the wards were not very clean and needed updating and that their Section 17 leave had been cancelled at short notice.

How we carried out this inspection

The team that inspected the hospital comprised one inspection manager, three inspectors, one medicines inspector, one Mental Health Act reviewer, two specialist advisors with specific experience of working in this type of setting and two experts by experience (who were offsite). Before the inspection visit, we reviewed information that we held about the hospital.

During the inspection visit, the inspection team:

- visited the acute and PICU wards and the forensic inpatient secure ward, looked at the quality of all the ward environments and observed how staff were caring for patients
- spoke with seven patients who used the services and eight family members
- looked at 14 electronic and paper copies of care and treatment records of patients
- observed a multidisciplinary team meeting and a shift handover meeting
- spoke with staff including the hospital director, ward managers, consultant psychiatrists and ward doctors, the clinical pharmacist, members of the multidisciplinary team, social workers, nurses and health care assistants
- reviewed a range of documents relating to the running of the service
- looked at medicines management, including medicine charts, associated Mental Health Act documentation, and physical health monitoring following administration of rapid tranquilisation.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

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

- The service must ensure that patient risk assessments are always reviewed regularly, including after any incident and patient observations must be carried out as prescribed, in order to provide care and treatment to patients in a safe way (Regulation 12, of the Health and Social Care Act 2008 (RA) Regulations 2014).
- The service must ensure that there are always effective governance processes in place to support good quality of care delivery and ensure there is clear oversight of care by leaders of the hospital, so action can be taken quickly to make improvements. (Regulation 17, of the Health and Social Care Act 2008 (RA) Regulations 2014).

Forensic inpatient or secure wards

- The service must ensure the ward environment and equipment are generally safe, thoroughly cleaned and well maintained (Regulation 12, of the Health and Social Care Act 2008 (RA) Regulations 2014).
- The service must ensure that the audit programmes are robust enough to identify all potential risks, with clear actions for minimising or removing such risks in a timely way. (Regulation 17, of the Health and Social Care Act 2008 (RA) Regulations 2014).
- The service must ensure all patient feedback or concerns are always documented with clear actions for how staff will address them (Regulation 17, of the Health and Social Care Act 2008 (RA) Regulations 2014).

Action the service SHOULD take to improve:

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

- The service should ensure that old Mental Health Act documentation to authorise treatment available in patients medicine charts is promptly removed.
- The service should ensure that staff clearly and accurately describe patients' section 17 leave on their care plans.
- Managers should ensure all staff have an appraisal of their work.

Forensic inpatient or secure wards

- Staff should ensure they support patients to utilise their section 17 leave. Staff should ensure that when patients section 17 leave was cancelled at short notice, this was clearly documented with the rationale.
- The service should ensure the food is consistently tasteful.
- Staff should consider improving on the ward décor and make the environment more therapeutic.
- Managers should ensure all staff have an appraisal of their work.
- Staff should ensure that there are specific and detailed care plans for patients in line with recommendation from clinical specialists.
- The service should consider taking proactive steps to support patients to access opportunities for work and education.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

There were safety concerns identified on Michael Shepherd ward. The wards were not clean and well-maintained.

Safety of the ward layout

There were potential fixed ligature anchor points at numerous points throughout the wards. Although staff had completed a ligature audit for Michael Shepherds ward, and identified these points on the audit, there were no actions for how they will reduce the risks in all but one of the ligature points identified. The action was for them to remove and replace the item but there were no clear timeframes for when this will happen.

The provider told us there was a refurbishment programme for each ward and the plan was for forensic inpatient secure services to move to the Elizabeth Anderson ward which had been refurbished. However, there were no clear timeframes for this, and the hospital refurbishment programme had been suspended. The provider informed us that they were mitigating the ligature risks using CCTV across the ward including patients' bedrooms. The provider told us that they routinely asked patients for consent to be monitored via CCTV. Patients who had not given their consent would be monitored via CCTV under the Mental Health Act 1983. The CCTV footage was monitored by an external organisation who alerted staff by phone when there was a concern. Staff told us high risk patients were placed on enhanced observation to reduce the risk.

Maintenance, cleanliness and infection control

Ward areas were not very clean, were not well maintained. The wards looked tired, needed updating and were not very tidy. All patients we spoke to said that the cleanliness on the ward needed improvement. The air conditioner in the quiet room was broken and the vent space was boarded with plywood.

Furnishings in the quiet room and the getaway room were not in good order. For example, we saw that there were broken cabinets in the getaway room and the sofa in the quiet room was ripped.

Although the wards had completed an infection prevention and control (IPC) audit in February 2021 and completed all actions in March 2021, we saw that the ward was dusty, feedback from patients was that the wards were not thoroughly cleaned.

Staff told us that the dishwasher was always breaking down and the plan was for it to be replaced, however it was not clear when this would happen.

The kitchen fridge temperature was not regularly checked. There were six days in August 2021 where the fridge temperatures were not checked.

The service did not have a seclusion room. Staff told us patients that needed seclusion had to be taken to the seclusion room downstairs when the seclusion room on adjacent Elizabeth Anderson ward was being used. We saw on inspection that the room was being used by a patient on long term segregation. The provider confirmed, that although this was not normal practice, a patient had been secluded in the downstairs room on one occasion since April 2021. Staff confirmed that they may have to convey a restrained patient to the downstairs seclusion room via the stairs which could present a risk to the patient and staff.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff monitored the clinic room and fridge temperatures, and they were within recommended ranges.

Safe staffing

The service had enough nursing and medical staff, to provide care and treatment for patients. However, the service was using a high number of agency staff.

Nursing staff

The service had enough nursing and support staff to keep people safe. Patients told us there was always a nurse around when they needed one, although they could be very busy.

Staffing rotas from May to July 2021 showed that there was always a registered nurse on every shift. On two occasions when there was no registered nurse, the hospital director and ward manager covered the shifts to ensure patients care and treatment needs were met.

However, the service was reporting a high vacancy rate for permanent registered nurses. The service had only one permanent registered nurse with six vacant registered nursing posts. Shifts were covered by agency and locum staff. Managers told us they only requested staff that were familiar with the service to ensure there was continuity and consistency of care.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Requires Improvement

Forensic inpatient or secure wards

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers had autonomy to staff their wards, and could adjust staffing levels according to the needs of the patients

Due to the closure of two wards as part of the hospitals action plan following the last inspection, the service was now overstaffed for healthcare support worker positions.

Short notice agency staff usage was reducing from 19.6% in April to 9.3% in July 2021. Long-term use of locum staff had reduced slightly from 29.8% to 24.1% between April and July 2021.

The sickness rate across the hospital had been fluctuating from 2.8% in May to 19% in June 2021. Although the average sickness rate in the last 12 months had been around 6%.

Staff turnover rates was high for all staff groups. The turnover rate was 96.4% for nurses, 65% for therapy staff, 113% for healthcare assistant.

Patients told us their escorted leave had been cancelled, although it was not clear if this was due to staffing issues. Carers reported that staff could do more to encourage and support patients to go out for fresh air.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

The hospital director told us they were actively recruiting staff and were increasing the pay for registered by six thousand pounds which was a 20% raise above England and NHS average with huge incentives and welcome bonuses to attract staff.

Medical staff

The service had enough daytime and night-time medical cover and a doctor was available to go to the ward quickly in an emergency. Although patients and carers told us sometimes it can take hours to see a doctor when requested in a routine non-emergency situation.

The doctors knew their patients well and involved them in their care. When the ward consultant was on leave or off work, there was adequate cover from consultants on other wards.

The hospital was reporting an average turnover rate of 21.1% for medical staff in the last 12 months. We saw that there was a spike in the turnover rate June and July at 41.4% and 40.7% respectively. The provider reported that this was due to the closure of two wards and changes in the underlying budget structure.

Mandatory training

Managers monitored mandatory training and alerted staff when they needed to update their training. However, staff on Michael Shepherd were not meeting all of their training targets.

Requires Improvement

Forensic inpatient or secure wards

Across the hospital, 90% of staff had completed their mandatory training, which was above the 85% target. However, 79.2% of staff on Michael Shepherd ward had completed their mandatory training. Staff told us that the data might be incorrect due to staff moving across from the other wards that were closed. Staff on Michael Shepherd ward were not meeting the training target for Mental Capacity Act 59%, cyber security 65%, infection control 65% and managing challenging behaviour 65%.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission/ arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a recognised risk assessment tool.

Management of patient risk

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

Staff could observe patients in all areas of the ward. The wards had CCTV, which was being monitored 24 hours of the day, 7 days of the week by an external organisation and alerted any incidents via a dedicated mobile phone.

The provider had a search policy. Staff followed the provider's policy for searching patients' bedrooms. Staff only searched patients who had been out on leave, but this was not always consistent.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. There were ongoing discussions by the senior leaders and ward staff requiring all wards to keep a log of reducing restrictive practices which was then be reviewed by the MDT.

Staff told us they made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff told us they will always talk to the patient to calm and reassure them.

There were 35 incidents on Michael Shepherd ward in June 2021, and 10 of these involved the use of restraint and one involved the use of rapid tranquilisation.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation.

Requires Improvement

Forensic inpatient or secure wards

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

There was one safeguarding on Michael Shepherd ward in June that reached Section 42 threshold, and six across all wards. The action was for the social worker to meet with the ward managers to look at root causes.

The social worker was working with the ward managers to ensure that incidents reporting was consistent with the number of safeguarding referrals. This was to ensure that staff were always making appropriate safeguarding referrals.

Staff access to essential information

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

Patient notes were comprehensive, and all staff could access them easily. On our last focussed inspection, we saw that the service had only electronic records of patients and when the systems were down staff could not always access the records. On this inspection we saw that patients now have back up paper records, and staff made sure all records were up to date and complete.

When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely.

Medicines Management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff could access up to date policies to safely manage people's medicines. Staff were trained in the safe handling of medicines and undertook annual training for rapid tranquilisation. Prescription charts were compliant with medicines specified on Mental Health Act documentation.

Requires Improvement

Forensic inpatient or secure wards

Staff offered and administered medicines to patients at the times prescribed. Where patients refused their medicines, staff offered these later if appropriate or documented their refusal on the prescription chart. The service had links with the acute trust if patients required physical treatments that the service did not provide, for example intravenous (IV) fluids.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. A clinical pharmacist visited weekly to screen prescription charts and check medicines safety on all wards. Patients could arrange a time to speak to the pharmacist during their visit if needed. Ward staff acted on recommendations made by the pharmacist and were open to learning. An internal league table of how recommendations were acted on had helped to improve their response times.

A speciality doctor was available 24 hours a day, seven days a week to prescribe for patients' physical conditions. A consultant psychiatrist reviewed patients medicines regularly. Patient management and treatment was discussed at staff handover meetings and weekly MDT meetings.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. All medicines were stored securely. The service held an appropriate range of emergency medicines, including oxygen, these were checked in line with the providers policy.

Staff ensured that controlled drugs were managed in line with legal requirements. There was excess stock due to the closure of some wards and stock being transferred. The service explained that they were addressing this with the support of the pharmacist. The pharmacist explained that they audited the ordering of medicines liable for misuse and had no concerns currently.

Staff followed current national practice to check patients had the correct medicines. Medicines reconciliation took place at admission. Doctors were available to prescribe for patients out of hours.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Medicines incidents, including any use of rapid tranquilisation were reported via the providers incident management system. Governance meetings were held to discuss trends in incidents and lessons learnt.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The service had a policy for the 'Prevention and Management of Disturbed/Violent Behaviour.' Patient's prescription folders included 'calm cards' and support plans for staff to know how to deescalate unwanted behaviours.

Staff applied de-escalation techniques before administering 'when required' medicines for the management of violence and aggression. Staff used rapid tranquilisation only when de-escalation was ineffective.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. Staff monitored people's physical health when rapid tranquilisation was administered and recorded their vital signs. Patients were reviewed and discussed at handover and clinical team meetings after rapid tranquilisation was administered. Patients told us that the doctors discussed with them any side effects they might experience from taking prescribed medication.

Staff monitored and recorded patient's blood sugars.

Requires Improvement

Forensic inpatient or secure wards

The service had access to a diabetes nurse specialist for advice and we saw letters attached to care records detailing diabetes management plans

Track record on Safety

The service reported five serious incidents between May and July 2021. These incidents were related to allegation of inappropriate restraints of patients by staff, and patients swallowing objects which could cause harm requiring assessment at Accident and Emergency unit.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy.

Staff reported serious incidents clearly and in line with provider policy. The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. There was an incident report and lessons learnt bulletin displayed throughout the wards including in staff toilets.

Are Forensic inpatient or secure wards effective?

Good

Our rating of effective stayed the same. We rated it as good.

Assessment of need and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans were personalised, holistic and recovery oriented.

Requires Improvement

Forensic inpatient or secure wards

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patients' needs changed. Care plans were generally personalised, holistic and recovery orientated.

Best practice in treatment and care.

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service, and they delivered care in line with best practice and national guidance. Staff made sure patients had access to physical health care, including specialists as required. For example, we saw that staff made appropriate patient referral to a diabetic specialist. Staff identified patients' physical health needs and recorded them in their care plans.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, staff were supporting patients to quit smoking by helping them access nicotine replacement therapies. Staff supported patients to plan their diets to help them manage their weights.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

All patients had an individualised activity timetable that were created with the occupational therapist with set goals to support the patient's recovery and develop skills needed for daily living.

Staff used technology to support patients.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. However, the appraisal rates were low.

The service had a full range of specialists to meet the needs of the patients on the ward.

Managers ensured staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff.

Requires Improvement

Forensic inpatient or secure wards

Managers gave each new member of staff a full induction to the service before they started work.

The appraisal rate was 77%% which was below the hospital target of 85%.

Managers supported non-medical staff through regular, constructive clinical supervision of their work.

Managers supported medical staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

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

Managers recognised poor performance, could identify the reasons, and dealt with these.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations including the police, commissioners and local authority safeguarding teams.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up to date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Requires Improvement

Forensic inpatient or secure wards

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Although some patient had reported that their leave had been cancelled at short notice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Good Practice in applying the Mental Capacity Act

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

Staff received training in the Mental Capacity Act and had a good understanding of at least the five principles. However not all staff had completed their Mental Capacity Act training.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

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

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Are Forensic inpatient or secure wards caring?

Requires Improvement

Forensic inpatient or secure wards

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff were generally kind and compassionate, although patients and carers told us some staff could be rude and inconsiderate.

Staff respected patients' privacy and dignity and spoke to patients in a respectful and caring way. For example, we saw that staff spoke to patients involved in an incident in a calm, non-judgemental and reassuring way. However, patients reported that there had been occasions where female patients were restrained by male only members of staff while they were being forcibly injected in their buttocks, and this was not always very dignifying.

Staff encouraged patients to take part in activities and they spent time to reassure patients when they had concerns. Although one carer told us that staff could do more to encourage patients to attend to their personal hygiene.

Staff supported patients to understand and manage their own care treatment or condition. Patients and carers spoke very highly of the medical team of how very kind and supportive they were.

Staff gave patients help, emotional support and advice when needed. Staff debriefed and supported patients who were involved in or had witnessed an incident.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff involved patients and gave them access to their care planning and risk assessments. Patients told us staff ensured they were actively involved in their care planning and risk assessments.

Although staff told us they involved patients in decisions about the service when appropriate, it was not clear how this was done. The 'you said' and 'we did' board did not have any records of what patients told staff and what staff had done. Staff told us it was likely someone had wiped the board clean. The board contained information such as OT, quiet time and completion date, but it was not clear what these referred to.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Requires Improvement

Forensic inpatient or secure wards

Staff informed and involved families and carers appropriately.

Staff supported, informed, and involved families or carers. However, one carer informed us staff did not always involve them in the patient's medication.

Staff helped families to give feedback on the service. The hospital informed us they had undertaken a friends and family test for people to give feedback about their care and treatment, but they had not received any response. The teams were exploring more productive ways of capturing people's experiences.

Staff gave carers information on how to find the carer's assessment.

Are Forensic inpatient or secure wards responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and Discharge

Staff planned and managed discharge well. There were three delayed discharges, and reasons for discharge was clinical. Staff were working with commissioners and care coordinators to find appropriate placement for these patients.

Bed management

The service had suspended admissions to the wards, and only admitted new patients under special circumstances, such as the acuity of the patient and only if they fit within the admissions criteria. Managers monitored the bed occupancy which was below 85%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The service had low out-of-area placements.

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

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

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Requires Improvement

Forensic inpatient or secure wards

Managers monitored the number of delayed discharges. There were four delayed discharges and some patients had been with the service for a long period of time. Staff told us they were working with care coordinators and commissioners to find appropriate placement for these patients.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy.

The environment on Michael Shepherd ward did not promote patient recovery. The furnishing and equipment were in need of repair or replacement. The food was not always very tasteful. However, the rooms were en suite, and patients could personalise them.

The ward was not very therapeutic, and the environment did not promote recovery. The wards were poorly lit with very few decorations. During our inspection, we saw that the windows were shut, and we observed the ward was not very airy. Although there were quiet areas on the ward for patients, we observed that the alarms were ringing very loudly across the wards for long periods of time including in the quiet room which could be distressing for patients.

The wards environment was not very therapeutic. There was very minimal artwork, decorations and designs. The provider informed us that the risk profile of the client group required a more sterile environment and that they were exploring the options of adding more murals.

The food menu consisted of a range of food including vegetarian and vegan options. However, patients told us the food was not always tasteful, which meant they sometimes chose to order takeaway.

Each patient had their own bedroom which they could personalise. There were wardrobes and storage places in the room for them to keep their personal possessions.

The service had a full range of rooms and equipment to support treatment and care including a quiet room and an activity room which were accessible to patients. There was a visitor's room off the ward where patients could meet with their visitors privately.

Patients were allowed their mobile phones when risk assessed and safe to do so. They were asked to sign a mobile phone contract which defined the terms of their mobile phone use. Patients who did not have a mobile phone could use the ward phone in private.

Patients could make their own hot drinks and snacks and were not dependent on staff. We saw that some patients had full kitchen access and can make their own food and drinks.

Patients' engagement with the wider community

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

Requires Improvement

Forensic inpatient or secure wards

The general feedback from staff and patients was that the service could improve on how patients were supported to access opportunities for work and education. Although all patients had an individualised activity timetable, it was not always clear how staff were supporting patients to gain meaningful education and employment.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There were access lifts for people with mobility problems or wheelchair users.

Staff made sure patients could access information on treatment, local service such as advocates, their rights and how to complain.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Although patients told us that the taste and quality of the food could be better.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. The service had received 14 formal complaints between May and August 2021. Nine of these complaints were related staff attitude, of which two of them were partially upheld.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

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

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

Requires Improvement

Forensic inpatient or secure wards

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, managers told us that patients reported that when there was an incident, all staff rushed to the scene of the incident, leaving the other patients unattended which made them feel unsafe. Staff on general observation were now required to remain with the other patients whenever there was an incident on the wards.

The service used compliments to learn, celebrate success and improve the quality of care.

Are Forensic inpatient or secure wards well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge, and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Patients and staff told us that leaders visited the wards regularly and were always available to offer help and support to the team.

Vision and strategy

Staff knew and were able to demonstrate the providers vision and value. The leaders informed us that the service was in a transition, and the plan was to ensure there were enough substantive staff to provide good quality care and treatment to patients, manage the acuity of the wards and reduce the levels of incidents. Staff were partners in this transformation, and they were positive about the future of the hospital.

Culture

Staff felt respected, supported, and valued. They felt they could raise any concerns without fear of retribution. Managers and senior leaders operated an open-door policy and staff were encouraged to speak up if they had any concern. The hospital had a freedom to speak up champion.

Governance

There were some risks and performance issues which we identified on previous inspection that had not been addressed. On the last inspection, we told the provider it must ensure that all risks were clearly identified and that there were clear action and timeframes for addressing those risks. On this inspection we saw that the although the service had completed a ligature audit, there were no actions for how the concerns identified will be addressed. For example, the ligature audit had identified ligature points across the ward, but it was not clear how this was being addressed. The wards were not always thoroughly cleaned but the IPC audit had not identified this as a concern.

Staff did not always ensure patients concerns and feedback were always recorded, and it was not always clear how these concerns were addressed. For example, the community meeting records between May and July 2021 did not clearly show how issues raised by patients were being addressed. The ‘you said’ and ‘we did’ board did not clearly show what patients have said and what staff did. The provider informed us following our inspection they encouraged patients to attend governance meetings to feedback or raise concerns about the service.

Requires Improvement

Forensic inpatient or secure wards

The hospitals governance meetings took place every month and it covered a wide range of issues including safeguarding, incidents, staffing and medication management and formal complaints.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. The provider had ensured that all staff had log-in details to access electronic patient records and there were also paper copies of key information in patient folders kept on wards.

There was a corporate risk register where all the risks across the service were recorded. The provider informed us that all the risks on the register were reviewed periodically. Actions to reduce the risks were detailed in the hospital's action plan and site improvement plan. For example, although staffing was on the risk register, we saw that the provider had clear actions for how they would address concerns around staffing.

Information management

Staff collected analysed data about outcomes and performance. The service had a secure record system. Staff told us the IT (Information Technology) systems were much faster and they could easily access information and complete tasks on time. This was significant improvement from our last inspection where the systems were very slow, and staff had to stay past the end of their shift to complete tasks or carry them over to next day.

Managers had systems and dashboards in place to support their role. This included information on complaints, training, and service performance data.

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 units safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

The ward environments were safe, clean, well equipped and well-furnished. However, they were not always well maintained.

Safety of the ward layout

Staff completed risk assessments of all wards areas and reduced any risks they identified. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. We saw completed ligature audits and security checks. However, the ligature audits were not always reviewed as planned. Managers told us that the service was undertaking new ligature audits and was working on a new plan to eliminate ligature risks, because the planned refurbishment programme for the hospital had been put on hold.

Staff had easy access to alarms and patients had easy access to nurse call systems. The wards complied with guidance and there was no mixed sex accommodation.

Maintenance, cleanliness and infection control

Ward areas were clean and well-furnished; however, they were not always well maintained. Staff made sure cleaning records were up-to-date and the premises were clean. Although staff could not show us records of cleaning that took place on weekends on inspection, the provider informed us following the inspection that these records were kept in a different folder. During the inspection we saw staff cleaning in all wards. We also saw completed handwashing and infection prevention and control audits with action plans.

The wards generally looked in need of refurbishment and some repairs were needed. For example, on Edith Cavell ward the laundry room door was in need of repair. Repairs were taking place for a water leak in the area that led to the garden and the ward manager's office. The Wendy Orr ward looked in need of redecoration. We saw stains on the walls and carpets and there was a strong odour in some areas.

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

Requires Improvement

Seclusion room

The seclusion room in Wendy Orr ward allowed clear observation and two-way communication. It had a toilet and a clock.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained and cleaned equipment. All medicines were stored securely. The service held an appropriate range of emergency medicines, including oxygen, and these were checked in line with the provider's policy. The clinic room and fridge temperatures in Edith Cavell ward were monitored and were within recommended ranges. Controlled drugs were managed in line with legal requirements.

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, vacancy rates remained high for permanent registered nurses.

Nursing staff

Vacancy rates remained high for permanent registered nurses, although shifts were covered by agency staff. On Edith Cavell ward there were three substantive registered nurses employed and on two on Wendy Orr. Both wards needed 9.6 full time equivalent of registered nurses when operating at full capacity. During our inspection visit we saw senior management supporting staff on the wards when agency nurses failed to arrive for work. The provider told us that they had implemented a recruitment plan since our last inspection in May 2021, and that the closure of the Elizabeth Anderson and Amy Johnson wards had assisted the hospital with having a higher number of permanent healthcare assistants. The service was also recruiting for a permanent director of clinical services. Managers told us that senior Priory management had agreed to cap the number of admissions and to not reopen any of the closed wards until the hospital had recruited a good number of registered nurses.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The ward managers could adjust staffing levels according to the needs of the patients.

The service had low staff sickness, but high staff turnover rates. Managers told us that they had identified patient acuity levels as the main reason for this. Managers were taking action to reduce the number of staff leaving, such as increasing the number of debriefs and welfare activities for staff, and by introducing psychology support sessions.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The service had enough staff on each shift to carry out any physical interventions safely. Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. There were a consultant and a speciality doctor in each ward and managers could call locum staff when they needed additional medical cover. The hospital had recently recruited two new junior doctors.

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

Requires Improvement

Mandatory training

The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. The overall compliance rate for staff training for the Edith Cavell ward was 85.1% and for the Wendy Orr ward was 89.7%.

Assessing and managing risk to patients and staff

Staff followed best practice in anticipating, de-escalating and managing challenging behaviour, however, they did not always assess and manage risks to patients well. Staff used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission using a recognised tool. Although staff generally knew about risks to each patient and acted to prevent or reduce such risk, they did not consistently review and update patients risk assessments following an incident. We saw that staff had not reviewed and updated a patient's risk assessment following three separate incidents on Wendy Orr ward in July 2021.

Management of patient risk

Staff did not always ensure that patients' risks were sufficiently managed. Three out of four care plans on Wendy Orr ward did not include individualised interventions for patients' risk behaviours. Also, some risk assessments completed on admissions did not reflect the identified risk levels.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff had access to footage from CCTV and there were also mirrors to mitigate risks from blind spots in communal areas. However, we found some missed patient observations on Edith Cavell ward. On three separate occasions in one day, patients were only checked three times per hour instead of four, as per their prescribed observation levels. This meant that patients could be exposed to risk of harm.

Use of restrictive interventions

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. The service had a policy for the 'Prevention and Management of Disturbed/Violent Behaviour' and staff undertook annual training in the use of rapid tranquilisation. Patient's medication prescription folders included 'calm cards' and support plans for staff to know how to de-escalate unwanted behaviours. Staff we spoke with confirmed that restraint is rarely used and always use d-escalation techniques first.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. We reviewed five episodes of seclusion in the hospital over the past three months. We found full seclusion records, two of which were uploaded to the electronic patient records system. The records included appropriate observations from staff for the duration of the seclusion, and most of the nursing, medical and multidisciplinary reviews were completed in line with the Mental Health Act Code of Practice.

Safeguarding

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

Requires Improvement

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

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital had a safeguarding lead in place. Managers took part in serious case reviews and liaised with the appropriate external agencies.

Staff access to essential information

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

We found that staff access to essential information had improved since our last inspection. Staff told us they were able to access patients' care plans and risk assessments and issues with the electronic system had reduced. The provider had ensured that staff that did not regularly work at the hospital had log in details, so they could easily access electronic patient records. During this inspection visit we found that paper copies of patients' individual risk assessments were kept in their observations folders, together with a summary page with key information for each patient for easy access for staff.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff could access up to date policies to safely manage people's medicines and they were trained in the safe handling of medicines. New staff inducted into the service were given time to shadow others and learn the processes. Staff administering medicines were competency assessed when joining the service. Prescription charts were compliant with medicines specified on Mental Health Act documentation. Staff ordered discharge medication for patients from the pharmacy and in circumstances where discharge/leave was urgent, staff followed a standard operating procedure to prepare discharge medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. A clinical pharmacist visited weekly to clinically screen prescription charts and check medicines safety on all wards. Patients could arrange a time to speak to the pharmacist during their visit if needed. Ward staff acted on recommendations made by the pharmacist and were open to learning. An internal league table of how recommendations were acted on had helped to improve their response times.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. All medicines were stored securely. The service held an appropriate range of emergency medicines, including oxygen, these were checked in line with the providers policy. There was excess stock due to the closure of some wards and stock being transferred. The service explained that they were addressing this with the support of the pharmacist. The pharmacist explained that they audit the ordering of medicines liable for misuse and had no concerns currently.

Staff followed current national practice to check patients had the correct medicines. Medicines reconciliation took place at admission. Doctors were available to prescribe for patients out of hours.

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

Requires Improvement

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. Patients' medicines and their physical health were reviewed and discussed at handover and clinical team meetings.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff recognised incidents and reported them using an electronic system. We reviewed incident data for the past six months for the hospital and found that the number of incidents had reduced. Managers debriefed and supported staff after any serious incident. Managers investigated incidents thoroughly, checked for themes and shared learning with all staff. Staff met to discuss the feedback and looked at improvements to patient care. There were monthly lessons learnt meetings and bulletins were produced and distributed throughout the hospital for staff to remind themselves of key points and actions.

Incidents were discussed during clinical governance meetings. A percentage of incidents closed on the electronic record were reviewed during these meetings and the incidents were presented by categories and themes.

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

Good

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were, holistic and recovery oriented. However, care plans were not always personalised.

We reviewed the care plans of five patients on Edith Cavell ward and all the care plans for the four patients on the Wendy Orr ward. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Staff developed care plans that met patients' mental and physical health needs, and these were regularly reviewed by multidisciplinary teams. However, some care plans were not always personalised. For example, the views of the patients were not always sought.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

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

Requires Improvement

Best practice in treatment and care

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

Staff delivered care in line with best practice and national guidance, and they provided a range of care and treatment suitable for the patients in the service. Staff made sure patients had access to physical health care, including specialists as required. We saw evidence of staff taking appropriate actions to support patients to acute hospitals when needed. Staff told us that they maintained good relationships with the Priory physical health team and there were no issues with obtaining reviews regarding patients' physical health problems.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, patients told us that they received support to quit smoking, had meals with precalculated calories to help manage their weight, and had the opportunity to attend drug addiction support groups.

Patients on both wards had the opportunity to participate in a range of activities organised by the occupational therapy team. We saw activity timetables in display on Edith Cavell and Wendy Orr wards and observed staff respectfully asking patients if they wanted to participate in activities. However, patients were not able to use the hospital's gym as there was no instructor.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide quality care. They supported staff with supervision and provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the wards. For example, there were occupational therapists and assistants on each ward and the patients had access to psychology support. We attended a morning multidisciplinary meeting and saw that both psychologists and occupational therapists were organising drop-in sessions for patients for that day.

Managers gave each new member of staff a full induction to the service before they started work. Induction records indicated that all permanent and agency registered nurses and healthcare assistants had received induction. We spoke with agency and permanent staff and told us that the induction they received when they commenced employment at the hospital was comprehensive.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We reviewed the training records for the hospital and saw that mandatory training compliance was at 90%. Most of the staff had also completed competency assessments, such as medication management, seclusion, safeguarding and observations competencies.

Staff received regular clinical and managerial supervisions, however, the staff appraisals rate for the hospital was 77%.

Multi-disciplinary and interagency teamworking

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

Requires Improvement

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We attended a morning handover meeting on Edith Cavell ward and a multidisciplinary meeting for all hospital wards which was well attended. Staff discussed follow up actions, including liaising with external agencies and we observed that staff were sharing detailed information about patients and any changes in their care. We also observed that staff teams from different wards were supporting each other and responded to emergencies when needed.

We found that on Edith Cavell ward there was a daily handover meeting between medical and nursing staff. We observed a meeting and saw that information was shared in an effective way. Actions were discussed and tasks were allocated accordingly. There were many examples of referring patients to external specialists, such as diabetic specialists and neurologists.

Ward teams had effective working relationships with external teams and organisations. On Edith Cavell ward, staff had liaised with a community team to receive training and to identify ways to provide effective support to a patient with autism spectrum conditions. The guidance received was then included in the patient's observations folder for all staff to have quick access.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received training on the Mental Health Act and the Mental Health Act Code of Practice and had access to support and advice on implementing these. Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff told us that there was a Mental Health Act administrator for the all the Priory Hospitals in the region and an assistant specifically for the hospital.

All Mental Health Act documentation to authorise treatment was available in patients medicine charts. However, old authorisation documentation was not always removed. This could lead to staff using the wrong legal authority to administer medication.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed. All wards used a five-point risk assessment form when signing patients out on leave. This form included a risk assessment, description of patients clothing, destination and duration of leave, expected time of return and details of any escorts.

Patients had easy access to information about independent mental health advocacy. We saw advocates speaking to patients during our inspection visit.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand and recorded it in the patient's notes.

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

Requires Improvement

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. Sometimes there were discrepancies in the way staff described patients' leave on their care plans, however this appeared to be a wording issue and no patient had their rights infringed.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff assessed and recorded capacity to consent each time a patient needed to make an important decision. When staff assessed patients as not having capacity, they made decisions in the best interest of patients Staff received training in the Mental Capacity Act and knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Some staff exhibit good understanding of the Mental Capacity Act and gave examples of best interest decisions.

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

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff understood and respected the individual needs of each patient. They gave patients help, emotional support and advice when they needed it. Patients had access to a range of support, such as psychology and occupational therapy and there were regular drop-in sessions for them to attend. Members of the multidisciplinary team discussed their input and plans for the day during the morning multidisciplinary meetings.

Staff were discreet, respectful, and responsive when caring for patients. They spoke fondly about patients and felt happy when patients achieved their goals. Patients told us that staff treated them well, behaved kindly and respected their privacy and dignity. Families also told us that staff were polite and caring. A relative told us that their family member felt empowered by medical and nursing staff during ward rounds.

Involvement in care

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

Involvement of patients

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

Requires Improvement

Staff made sure patients understood their care and treatment and there were regular multidisciplinary reviews. We found that the service had sourced interpreters for two patients on Edith Cavell and Wendy Orr wards because English was not their first language.

Staff involved patients to their care planning and risk assessments, however this was not always clearly evidenced in all care plans. Patients told us that staff involved them in their care and their views were considered. Some patients told us that they were not given information on admission about their condition, rights and treatment, and did not have a copy of their care plans.

Staff made sure patients could access advocacy services. We saw advocates speaking to patients during our inspection visit.

Patients could give feedback on the service and their treatment and staff supported them to do this. We saw that the service had conducted discharged patient surveys and had produced relevant action plans.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed, and involved patients' families or carers. The service had carers' handbooks for each ward which included a range of information. Staff told us that they were organising a monthly online carers forum and a summer fete for carers. Each ward had a carers' lead who participated in monthly multidisciplinary meetings and produced relevant action plans.

Staff told us that a carers survey was last attempted in December 2020, but they did not receive any responses, so they were seeking alternatives ways of gaining feedback from carers. Some families told us that they did not know how to feedback to the service.

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

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

Managers made sure bed occupancy did not go above 85%. At the time of the inspection managers had capped the number of admissions on Edith Cavell ward to ten and on Wendy Orr ward to six, until they felt that that the hospital had

appropriate staffing levels. Some staff told us that admissions were managed effectively by the hospital's management. Staff told us that there was a cap to the number of admissions per week in order to give enough time to staff to understand the needs of the new admissions, and to be less unsettling for the other patients. Managers told us that they were reviewing the hospital's admission criteria for the acute and the psychiatric intensive care units.

The service had low out-of-area placements. Edith Cavell ward was commissioned by local clinical commissioning groups for patients who lived in the area.

Discharge and transfers of care

Staff planned patients' discharge and worked with care managers and coordinators to make sure this went well. Managers spoke to us about how the hospital was supporting patients to discharge and explained that care managers were regularly attending ward rounds and joined weekly calls to discuss discharges.

We saw discharge plans for patients on both wards. A patient on Edith Cavell ward told us that staff was effectively supporting them to put together a discharge plan.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. A patient told us that they were able to put photos of their family up in their bedroom. Patients had a secure place to store personal possessions. Families told us that they felt that patients' possessions were safe at the hospital. The service had quiet areas and rooms where patients could meet with visitors in private. Patients could make phone calls in private and there were outside spaces that patients could access easily.

Patients could make their own hot drinks and snacks and were not dependent on staff. Some families and patients told us that the food was good, however one patient told us that there had been a couple of times when they felt that food was not enough and had to ask for more. On both wards we saw that the menu was displayed in communal areas and included vegetarian options.

Patients' engagement with the wider community

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

Staff helped patients to stay in contact with families and carers. We saw that there were facilities for patients to make phone calls in both wards. Staff told us that they were organising a summer fete and they were planning to invite families and neighbours.

Patients had the opportunity to enter an artwork competition and if chosen, their work could then be displayed to the public in exhibition rooms in the capital.

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

Requires Improvement

Meeting the needs of all people who use the service

The service met the needs of patients, including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Staff helped patients with communication, advocacy and cultural and spiritual support. Occupational therapists were liaising with the local community to ensure that patients had access to local faith services if they wished to. The service ensured that patients had access to interpreters when needed.

Staff made sure patients could access information on treatment, their rights and how to complain. We saw that relevant leaflets and posters were in display on both the Edith Cavell and Wendy Orr wards.

Listening to and learning from concerns and complaints

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

Patients knew how to complain or raise concerns. Information was displayed about how to raise a concern in areas patients accessed. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints, identified themes and shared feedback appropriately.

We saw the hospital's complaints records and found that staff had responded appropriately to complaints. Staff had in place a tracking system to ensure that all actions were promptly completed. Records and actions were then reviewed at ward business and clinical governance meetings. No themes were identified.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge, and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Most of the staff members we spoke with told us that they were feeling positive about the hospital's management plans to implement improvements at the hospital. A staff member told us that leaders were making changes without consulting staff.

Vision and strategy

Staff knew and understood the provider's vision and values. We spoke to members of the senior management team and found that they were open and honest and clearly described their vision and plans for the hospital. They clearly explained their roles and how the teams worked to provide quality care.

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

Requires Improvement

Culture

Staff felt respected and valued. They told us that there was always someone to approach when they had concerns and spoke highly about the support they receive from the leaders. Some staff told us that their main concern was the hospital not having enough registered nurses and the impact of this if the service was to increase admissions. Staff could raise any concerns without fear.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that risk were not always managed well.

We reviewed community meetings between May and July 2021 and saw that there were not always clear actions for how staff were addressing concerns, issues or suggestions raised. We also found that both on Wendy Orr and Edith Cavell wards, community meetings were not taking place regularly.

There were no staff team meetings taking place on Edith Cavell and Wendy Orr wards, although such meetings were taking place on the Michael Shepherd ward. Although staff could give feedback or raise concerns directly with senior leaders via different mechanisms including monthly business meetings, hospital wide meetings, and other forums, there was no clear and consistent way of capturing and escalating feedback and concerns from the ward teams.

Leaders told us that they were working to improve governance processes and were focussing on what needed to be done to complete actions.

Management of risk, issues and performance

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. The provider had ensured that all staff had log-in details to access electronic patient records and there were also paper copies of key information in patient folders kept on wards.

The service had an electronic risk register where highest risks were clearly identified, however, it did not include the dates control measures were added, or when actions meant to be completed. We were not able to triangulate what was included on the risk register and clinical governance minutes to determine what has been completed, or what needed to be done.

Information management

Staff had access to sufficient equipment and information technology in order to do their work. The secure record keeping system was easily available to staff to update patient care records and to review when needed. Managers had systems and dashboards in place to support them in their role. This included information on complaints, training, and service performance data.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not ensure that there were always effective governance processes in place to support good quality of care delivery and to ensure that there was clear oversight of care by leaders of the hospital, so action can be taken quickly to make improvements. The service did not ensure that the audit programmes were robust enough to identify all potential risks, with clear actions for minimising or removing such risks in a timely way. The service did not ensure that all patient feedback or concerns were always documented with clear actions for how staff will address them.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure that patient risk assessments were always reviewed regularly, including after any incident, and patient observations were always carried out as prescribed, in order to provide care and treatment to patients in a safe way. The service did not ensure that the ward environment and equipment were always safe, thoroughly cleaned and well maintained.

Inactive