

# The Priory Hospital Southampton

## Quality Report

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

## Ratings

### Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

# Summary of findings

## Overall summary

We rated the Priory Hospital Southampton as good overall.

We last inspected the service in September 2015. Following that inspection, we took enforcement action against the provider, in the form of a warning notice. This was primarily in relation to failings in the provider's governance of the service that affected the safety and well-being of patients. We also gave the provider two Requirement Notices, relating to safe care and treatment and statutory notifications, which we followed up on at this inspection. We found the provider had taken appropriate steps to address the concerns we had found previously and the hospital's staff had worked hard to implement significant improvements.

At this inspection (8 and 9 February 2017), we found the provider had taken appropriate steps to ensure the safety of patients and staff at the service. They had taken appropriate steps to address risks to patients from the environment. Wards were well maintained and in a good state of repair. As we found at our previous inspection, there remained a number of issues related to the physical environment and layout of the wards. These issues were partly due to the hospital being in an old, historic building. For example, internal walls and alcoves on corridors made it difficult to ensure good lines of sight for staff in all ward areas. The provider had introduced additional measures to address those issues with the environment.

Sufficient numbers of staff of the right grades and experience were generally available to meet the needs of patients. There was a good range of activities, education and therapeutic interventions. However, patients said that there were fewer outings and activities on the weekends. Ward teams were multi-disciplinary and had the input of a full range of staff. Ward staff also worked effectively with other teams involved in each patient's

care. The provider ensured staff had access to a broad range of in-house and additional specialised training, together with sufficient supervision. Staff felt well supported in their roles and expressed a sense of pride in the standards of care they were providing. Ward and hospital managers were thought well of by staff, and were able to lead with appropriate authority.

Staff were sincere and caring in the way they interacted with and supported patients. They involved people in their care, and offered patients choices and access to advocacy. There was appropriate involvement of families and carers. Patients were able to give feedback on the service they received, and met regularly with staff to discuss general issues or concerns.

Staff felt able to raise concerns without fear of victimisation, and told us their immediate managers were supportive and listened to them. They described the hospital's senior team as responsive and open to suggestions for improvements to services. Although staff morale had been affected by changes that had taken place at the hospital in recent months, most of the staff we spoke with told us they were happy to be working at the hospital and that morale was improving.

However, we also found a number of areas where the provider could make further improvements:

Some staff told us they did not always feel sufficiently trained or prepared to support the high and complex needs of some of the patients. Similarly, a number of patients told us that they felt the care and support delivered by agency staff was not always to the standard provided by the hospital's permanent staff.

Although we found improvement since our previous inspection, there remained some variance in quality of care records across the three wards. We saw evidence of ongoing support for people's physical health.

# Summary of findings

## Contents

### Summary of this inspection

	Page
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	5
Information about The Priory Hospital Southampton	5
What people who use the service say	6
The five questions we ask about services and what we found	7

### Detailed findings from this inspection

Mental Health Act responsibilities	13
Mental Capacity Act and Deprivation of Liberty Safeguards	13
Overview of ratings	13
Outstanding practice	28
Areas for improvement	28
Action we have told the provider to take	29

Good 

# The Priory Hospital Southampton

## Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Child and adolescent mental health wards; Specialist eating disorders services;

# Summary of this inspection

## Our inspection team

The inspection was led by Chris Lee, inspector

The team that inspected this core service comprised an inspection manager, three inspectors, an assistant inspector, and a psychologist who specialises in eating disorders.

## Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive inspection programme. This was a comprehensive inspection, which covered the key lines of enquiry for all five domains: safe, effective, caring, responsive and well led. We last inspected the service in September 2015. We took enforcement action against the provider following that inspection, in the form of a warning notice. We subsequently returned to the hospital to check the provider had made the improvements required and found that they had improved a number of

their governance and management systems to improve safety. We also gave the provider two Requirement Notices following the September 2015 inspection, which we followed up on at this inspection:

Regulation 12 HSCA (Regulated Activities) Regulations 2014 - Safe care and treatment; and

Regulation 18 Care Quality Commission (Registration) Regulations 2009 (Part 4): Notification of other incidents.

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location and asked a number of other organisations for information and feedback.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environments and observed how staff cared for patients;
- spoke with 16 patients who were using the service and four of their carers;
- spoke with the registered manager, the recently appointed interim hospital director, the deputy hospital director and the ward managers;
- spoke with 21 other staff members, including doctors, nurses, health care assistants, an occupational therapist and a psychologist;
- looked at 17 care and treatment records of patients; and
- considered a range of policies, procedures and other documents relating to the running of the service.

## Information about The Priory Hospital Southampton

The Priory Hospital Southampton is registered to provide the following regulated activities:

- Accommodation for persons who require treatment for substance misuse;

# Summary of this inspection

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

An interim hospital director was in post at the time of our inspection, but we also met with the previous hospital manager who was still the registered manager of the service at the time of our visit.

The hospital provides therapeutic and recovery focused residential treatment as well as day care and outpatient services. The hospital also provides specialist inpatient services for children and adolescents.

There are three wards at the hospital, each of which we visited as part of this inspection:

## Kingfisher ward

**Core service provided:** Child and adolescent mental health wards

**Male/female/mixed:** mixed

**Capacity:** this was reduced to five beds at the time of our inspection, but was scheduled to revert back to 12 beds at the beginning of May 2017

## Sandpiper ward

**Core service provided:** General psychiatry, and addictions and treatment

**Male/female/mixed:** mixed

**Capacity:** 17 beds

## Skylark ward

**Core service provided:** Eating disorders

**Male/female/mixed:** mixed

**Capacity:** this had been increased to 18 beds at the time of our inspection, but was scheduled to revert back to 11 at the beginning of May 2017

## What people who use the service say

We spoke with 14 patients across the three wards during the inspection. We also spoke with relatives of two patients.

Patients were positive about the care and treatment they received, and about the hospital's staff and environment.

Patients on Sandpiper ward told us they had been in different hospitals previously and that this was better than other services they had accessed. They told us they were given more choices, the staff were compassionate and caring, there were more therapeutic sessions, and that their days were well structured. There was focus on their recovery. Patients reported that they felt safe on the ward, and had not experienced any episodes of aggression or violence.

Patients on Kingfisher ward told us staff were very caring and respectful. They emphasised that staff were

understanding and not judgemental. They told us they had access to their care plans, and were involved in completing them weekly. They said they felt safe on the ward.

Patients on Skylark ward told us they were involved in their care as far as possible. They felt supported by staff and despite the treatment regime and expectations being challenging and, at times, difficult they felt positive about the care provided. Some staff were described as being 'amazing' and 'going above and beyond'. However, patients who were admitted in December 2016, when the ward was extended to include some of the beds on Kingfisher ward, said they thought staff and patients had at that time been unsettled.

We spoke with two relatives of patients on Skylark ward, who both told us they felt fully involved in their relative's care.

# Summary of this inspection

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

We always ask the following five questions of services.

### Are services safe?

We rated safe as good because:

- The provider was taking appropriate steps to address risks to patients from the environment. A revised ligature audit, carried out in November 2016, pulled together remaining identified ligature risks, with clear actions for their mitigation or dates for their removal. Designated staff had ligature training, which they then cascaded to their teams. Wards had access to resuscitation equipment and emergency drugs that were regularly checked. We found there was an appropriate standard of hygiene and cleanliness. The wards had good quality furnishings, were well maintained and in a good state of repair.
- We observed sufficient staff in communal areas of wards when patients were present. Patients and carers told us that there were always qualified staff available. The provider's staffing 'ladder' tool allowed for adjustments, for instance if 1:1 observation was required or patients' risks increased. Managers and senior staff told us they were able to alter staffing levels in order to meet the needs of the patient group. Agency and bank nurses, when used, were generally familiar with the wards. All bank and agency staff had an induction and training to complete before they worked on the wards.
- Patient records contained completed risk assessments, carried out at or soon after admission, and updated regularly and following incidents. Risks were focussed around patients' physical needs and mental health issues.
- Improved systems and procedures for reporting and learning from incidents, implemented by the provider following our previous inspection, were now effectively embedded. The provider had taken necessary steps to provide assurance that their systems and processes worked effectively to ensure the Care Quality Commission now received all statutory notifications as required.
- Staffing levels on Kingfisher ward affected how often patients were able to go out of the unit into the enclosed unit garden or the hospital grounds. Due to identified risks, young people were not able to go out unescorted, and there were insufficient staff to escort all patients, at all times.

Good



# Summary of this inspection

- Staff had not completed temperature checks of a medicine refrigerator on a number of occasions over the previous four months. This meant there was a risk that medicines requiring refrigeration may not have been stored at the correct temperature, which would affect their efficacy.

## Are services effective?

We rated effective as good because:

- Staff carried out comprehensive assessments, at or soon after patients' admissions to the hospital. Those assessments included mental state and physical health, risk and future needs, and included the initial observation required. Care plans were generally up to date, personalised and recovery oriented. Care plans and confidential records were stored securely and available for staff use as required.
- Medication records demonstrated consultants and doctors followed appropriate National Institute for Health and Care Excellence (NICE) guidelines, and prescribed treatments within British National Formulary (BNF) limits. Patients received a wide variety of different psychological therapies. All patients accessed individual therapies, and there was an active group therapy programme. There was a well-balanced, individualised timetable of activities, education and therapeutic interventions.
- Ward teams were multi-disciplinary and had the input of a full range of staff. Ward staff worked effectively with other teams involved in the individual's care. Staff were able to access a broad range of in-house training and additional specialised training, received sufficient supervision and felt well supported in their roles

However:

- Although we found improvement since our previous inspection, there remained some variance in quality of care records across the three wards. An audit by the provider in January 2017 had already identified a number of improvements required to some patient care plans, in-line with our findings.
- On Sandpiper ward, staff raised with us that at times they did not feel sufficiently trained or prepared to support the acuity levels and complex needs of some of the patients admitted to the ward under the block contract with the local NHS trust.

Good



## Are services caring?

We rated caring as good because:

Good



# Summary of this inspection

- We observed staff were sincere and caring in the way they interacted and gave support, spoke appropriately and respectfully, and were discreet when discussing individual issues with patients. Patients told us they were given choice, including over food, activities and therapy sessions. They felt that staff supported them at all times in a respectful manner. Patients on Skylark ward told us that they felt supported and, despite their individual treatment regimes at times being challenging, they felt positive about the care provided by staff. Some staff were described as being amazing and going above and beyond what was expected.
- Admission processes informed and oriented patients to the ward and hospital. We saw ways in which patients were involved in the planning of their own care and supported to maintain their own independence. Staff supported patients to access independent advocacy input, which had increased considerably in the previous 12 months. We saw evidence of the appropriate involvement of families and carers.
- Patients were able to give feedback on the service they received in a number of ways, including regular one to one meetings with named members of staff and community meetings with staff to discuss general issues or concerns. Patients were able to get involved in decisions about their own care and the wider service provision, which included involvement in the recruitment of staff. Upon discharge, patients were asked to complete a full survey about the service they had received. Returns from the most recent survey all contained positive responses about the quality of care and therapies provided.

However:

- Patients on Skylark ward also said there was a difference between the standard of support provided by regular staff and that provided by some agency staff, who they felt were not always understanding of their illness, specific needs and risks. Some of the patients on Skylark ward also said that the booklet they were given on admission had too much detail, which meant it was difficult to work out the important things such as what they could bring with them to the ward.
- Patients admitted to Skylark ward in early December 2016, when the eating disorder service increased to include rooms on the hospital's lowest floor, said it had been unsettling for both them and staff. They told us that as a result the atmosphere had not been as welcoming as it should have, and had at times been chaotic.

# Summary of this inspection

- On Sandpiper ward, although patients told us the care they received was exemplary, there was minimal documented input into care plans by patients, and it was inconsistent as to whether patients had signed or received a copy of their care plan.

## Are services responsive?

We rated responsive as good because:

- Discharge from the hospital was generally not delayed for anything other than clinical reasons, and there were clear admission and discharge pathways.
- The wards had a range of different rooms and equipment to support treatment and care. The provider had installed a new staff alarm system, which operated effectively to identify to ward staff exactly where in the hospital an emergency was taking place without causing unnecessary disruption to patients.
- The majority of patients on Sandpiper and Skylark wards were informal and so had access to the grounds surrounding the hospital. Wards had been adapted to support mobility and accessibility for disabled people. This included flat surfaces and ramps for wheelchair users and disabled adapted bathrooms.
- Patients generally had access to a broad range of activities, and told us the weekly day outings gave them something to look forward to. The feedback received from patients was that the food provided was of good quality, and patients were able to access hot drinks and snacks whenever they wanted them.
- At each of the wards, there was a range of information provided for people who used services. Staff were able to access the support of interpreters to meet the communication needs of patients for whom English was not the primary language. Patients knew how to complain and felt able to do so if they wanted to, and we saw examples of improvements made following complaints from patients.

However:

- As we found at our previous inspection, due to specific safety concerns related to many of the young people on Kingfisher ward, there was limited access to outside space for those patients. There was a separate enclosed outdoor space where they could go under staff supervision, but young people were not able to go out in the enclosed garden or the hospital grounds unescorted.

Good



# Summary of this inspection

- Patients on Kingfisher and Sandpiper wards told us that whilst there were a good variety of activities during the week, fewer outings and activities took place on the weekends, which tended to be less structured.
- Skylark ward was on the top floor of the building and accessible only by stairs. Due to the nature of the ward, which is the treatment of eating disorders, there was a risk that patients might use the stairs to excessively exercise or, conversely, may actually become too unwell to use the stairs.

## Are services well-led?

We rated well led as good because:

- Staff emphasised that care was at the centre of everything they did, and many of them expressed a sense of pride for the standards of care they were providing. Ward managers were able to give us detail about the organisation's values and vision, and believed that their teams worked to those values when supporting patients. Ward and hospital managers found the provider's senior management team approachable and supportive. Ward and hospital managers were highly thought of by their teams and were able to lead with appropriate authority.
- At our previous inspection, we identified serious failings in relation to the provider's recording, monitoring and reporting of incidents. At this inspection, we found the provider had taken all necessary steps to address those failings. We also found concerns related to the levels and monitoring of both rapid tranquilisation and restraint. At this inspection, we found the provider had taken all necessary steps to address those concerns.
- A range of meetings formed the provider's effective oversight and clinical governance of the hospital. Monthly clinical governance, medicines optimisation, senior management team, and health and safety meetings were all well documented. Weekly 'learning from experience' meetings fed directly into the clinical governance meetings, and included safeguarding, complaints, serious incidents, restraints and reviews of high-risk patients.
- Staff knew how to use the whistleblowing process and felt able to raise concerns without fear of victimisation. They told us that they raised concerns freely and openly, and had appropriate opportunities to feedback on services and input into service development. Figures supplied to us by the provider indicated that the staff sickness rate remained low, at less than 2% monthly, on average, for the previous 12 months.

Good



# Summary of this inspection

However:

- Staff morale had been affected in recent months, by changes to the wards and individual service sizes following commissioning decisions and contract changes. Staff on both Kingfisher and Skylark felt they had not been consulted properly or involved fully in the decisions around this change. We saw evidence that there had been communication with staff teams during the changes, but the hospital's managers acknowledged that the process and communication could have been handled better.
- Staff on Kingfisher ward were proud of improvements on the unit since our previous inspection, but felt that there had not been sufficient recognition from the provider for the changes they had helped to bring about.

# Detailed findings from this inspection

## Mental Health Act responsibilities

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

- At our previous inspection, we found there were effective systems in place to ensure adherence to the Mental Health Act (MHA). Those systems remained in place at this inspection.
- Staff had received training in the MHA and had a good understanding of the Act. Patients had access to independent mental health advocacy (IMHA) as and when required. Evidence was seen that staff explained patient rights under the MHA at admission, or when significant changes in their detention status occurred.

The hospital's MHA administrator had processes in place to ensure that this took place, and appropriate attempts were made by staff to revisit rights under the MHA if a patient lacked capacity to understand them initially. The hospital's MHA administrator was available to provide support to staff and ensure adherence to all aspects of the act. We found that appropriate forms were attached to medicine charts to confirm that correct steps to obtain consent to treatment had been followed. Detention paperwork was scrutinised and stored appropriately by the MHA administrator.

## Mental Capacity Act and Deprivation of Liberty Safeguards

### Good practice in applying the MCA

- At our previous inspection, we found there were effective systems in place to ensure adherence to the Mental Capacity Act (MCA). Those systems remained in place at this inspection.
- We saw mental capacity assessments and patients' consent were clearly recorded by staff in patient files. Staff were aware of and able to refer to information regarding the MCA and Deprivation of Liberty Safeguards (DoLS) on the provider's internal intranet. On Sandpiper ward, we saw that informal patients were asked to sign consent to treatment forms when they were admitted. We saw well-completed mental capacity assessments for patients, which were done when there was an indication that a patient's capacity may be

impaired. On one occasion, in line with the act's principles, when a doctor had felt that a patient's mental capacity would improve, they repeated the assessment the next day, which resulted in a different outcome from the initial assessment. We saw evidence of best interest decisions, made following correct processes. We also saw records of discussions and appropriate consideration given to DoLS concerning a patient, where ultimately the decision was that it was not an appropriate intervention in that instance.

- We found consent recorded in the CAMHS records and noted there was reference to Gillick competency where appropriate. Gillick competency relates to children and young people who are under the legal age of consent but deemed capable of consenting for themselves.

## Overview of ratings

Our ratings for this location are:

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

# Detailed findings from this inspection

## Notes

### Is the Priory Hospital, Southampton safe?

**By safe, we mean that people are protected from abuse and avoidable harm**

#### Safe and clean ward environment

- Due to the physical internal structure of the hospital, which is housed in a listed historical building, the layout of wards did not allow staff to observe easily all parts of the wards. The provider was taking ongoing measures to mitigate the risks this posed, including introduction and increased use of CCTV monitoring throughout the ward and communal areas. Patients were risk assessed and placed on an appropriate observation pattern according to perceived risk. We had a specific concern with recessed areas at the end of a corridor on one of the wards, which contained a door with a closer and door handle that could potentially be used to ligature out of staff's line of sight. Staff confirmed that they would not ordinarily check this area as part of their routine observations. Although there were no bedrooms on that part of the ward, the bedrooms next to the recessed alcoves were identified as low ligature risk, so patients who were potentially at increased risk of self-harm were placed there. We subsequently raised this with the hospital's managers at the time of inspection, to ensure they were aware of the risk. The provider had used a 'blind spot audit tool' in November 2016, to carry out a specific audit of blind spots. This identified blind spots and included actions to be taken to mitigate the risks. For example, the recesses between bedrooms on Kingfisher ward were to be better mitigated through the installation and use of CCTV as dome mirrors had been found to be ineffective. Similarly, for Sandpiper ward actions had been identified to mitigate blind spots, including the installation of mirrors and CCTV for out-of-hours coverage. On Skylark ward, the planned installation of a nurses' station at a mid-point on the main ward corridor would allow for better staff observation of patients.
- The provider had taken and was continuing to take, appropriate steps to address the risks from ligature points. A ligature point is an environmental feature or structure that is load bearing and can be used to secure a cord, sheet or other tether that can then be used as a means of hanging. We identified that there were a number of remaining ligature points on each of the

wards; however, the provider had made and continued to make further improvements as part of its ongoing provider-wide ligature reduction programme. A revised ligature audit, carried out in November 2016, pulled together remaining identified ligature risks, with clear actions for their mitigation or dates for their removal. Designated staff had ligature training, which they then cascaded to their teams. All wards had appropriate ligature cutters, which were easily accessible to staff and staff knew where they were kept. Each ward had designated 'safer' rooms, with anti-ligature fittings and fixtures, and the provider-wide ligature programme meant that additional rooms were going to be made more ligature-safe.

- Each ward had access to resuscitation equipment and emergency drugs that were regularly checked. Emergency drugs were stored in a sealed box with a list indicating contents and expiry dates. If the box seal was broken, a new box of drugs was ordered from the provider's preferred pharmacy provider.
- There was an appropriate standard of hygiene and cleanliness on the wards, with good quality well maintained furnishings throughout. Patients confirmed the wards were kept clean and tidy.
- There was an alarm system throughout the hospital. On Sandpiper ward, patients had access to a nurse call system and staff carried personal alarms. Whilst there were no nurse call bells in rooms on Kingfisher ward, all staff carried alarms. Allocated staff from all wards responded to each other's alarms. There was a 'ward incident management plan' that set out how staff were to support patients in the event of a disruptive or aggressive incident on the ward. Staff shared this with patients on admission, and updated the plan to reflect the specific needs and changing dynamics of patient groups.

#### Safe Staffing

- The provider's staffing 'ladder' tool was used to identify how many staff should be on duty in relation to the number of patients. The tool allowed for adjustments, for instance if 1:1 observation was required or patients' risks increased. Managers and senior staff told us they were able to alter staffing levels in order to meet the needs of the patient group. We checked previous staff rotas and confirmed that staffing figures were usually at the established figures for each of the wards. Staff sickness figures for the 12 months prior to our

# Detailed findings from this inspection

inspection indicated that monthly sickness averaged 2%, with a low of approaching 0% in August and a high of 3% in November 2016. Although staff turnover remained high, as we had found previously, slightly more staff had started work at the hospital in the previous 12 months than had left.

- The biggest staffing issue the provider faced was a sizeable number of vacancies for essential registered mental health nurses (RMN). At the time of our visit, there were vacancies for eight RMNs across the three wards, to replace the eight RMNs who had left the hospital in the preceding 12 months. Although nine RMNs had been recruited in the same period, eight of those had since transferred to bank and one had left the hospital. A mix of bank and agency staff covered any gaps on shifts resulting from vacancies.
- On Kingfisher ward, staff rotas indicated the ward should have two qualified nurses and one unqualified healthcare assistant (HCA) during the day; but due to the shortage of qualified nurses, they were currently running at two HCAs and one RMN. Following the closure of over half of the CAMHS beds, five of the unit's registered nurses had handed in their notice, resulting in a number of unfilled vacancies. The impact of this had not yet been felt on the staffing levels on the ward, as those staff were still working out their notice and the unit was not yet back to 12 beds. The unit tried to avoid using agency or bank as much as possible, to ensure consistency for the young people; however, this would possibly change once those RMNs had worked their notice, as the vacancies had not been filled. Following inspection, the provider advised us that they have recruited three long term agency staff to work on the ward.
- On Skylark ward, staffing consisted of two RMNs and five HCAs during the day. One of those staff worked a 'late long day', by starting later. Using the late long day they had found that they did not need an additional member of staff at night. They used regular night staff, but some staff rotated onto nights. Staff told us that at times the ward had felt short staffed.
- On Sandpiper ward, the provider had reduced staffing levels from six to four on day shifts when the ward was full. Staff had complained about this and, as a result, the manager had taken the decision to increase back to five dependent on the needs of the shift. At the time of inspection, staffing on the ward consisted of two qualified nurses and three HCAs.
- Agency and bank nurses, when used, were familiar with the wards. All bank and agency staff had an induction and training to complete before they worked on the wards. The ward manager on Sandpiper ward confirmed that they tried to use regular agency staff, if needed, and they were usually on the rota with a permanent member of staff during the week, however at weekend this was sometimes not possible.
- During our visit, we observed sufficient staff in communal areas of wards when patients were present. Staff and carers of patients on Skylark ward told us that there was always qualified staff around in communal areas. The ward was also about to have a nursing station with a computer and desk located in the main corridor, which would further enhance the staff presence. Patients told us there were enough staff for them to have regular one-to-ones. Staff and patients said that generally activities and escorted leave were not cancelled due to staffing; however, some patients told us that this had not been the case for the first few weeks after the CAMHS beds had changed to eating disorder beds. They said that at this point, staff were often too busy to escort patients and they would have to agree a later time for escorted leave.
- Staff on Sandpiper ward told us that ward activities were rarely cancelled due to staffing. In previous months, there had been instances of escorted leave or activities having to be cancelled due to staffing, but they assured us the situation was now much improved.
- On Kingfisher ward, staffing levels did potentially affect how often patients were able to go out of the unit. Young people were not able to go out in the enclosed unit garden or the hospital grounds unescorted. Risks presented by a busy main road nearby and from adult patients from other parts of the hospital made it difficult for the provider to safely manage potential risks to young people if they were unescorted outside the ward. Some staff told us that there were occasions when young people could not leave the ward when they wanted to due to staffing arrangements, but that it was not a regular issue.
- There was adequate medical cover available day and night, and a doctor was able to attend the wards quickly in an emergency. Consultant medical staff were on duty each day and a resident medical officer provided out of hours cover.

## Assessing and managing risk to patients and staff

# Detailed findings from this inspection

- We looked at 17 patients' care records across the three wards. We saw that staff completed risk assessments at or soon after admission, and then updated them regularly and following incidents. The provider had produced a 'how to' guide for 'risk assessment and narrative in care notes', which served as a guide for staff on all wards, giving clear step by step instructions for the assessment and write-up of risks.
- On Kingfisher ward, there were detailed and up to date risk assessments. Risk assessments were updated prior to patients going on leave and following any change in the young person's mental state or behaviour. Observations were allocated to a specified staff member to carry out and we saw that these were recorded effectively. Observations reflected what was documented in individual risk assessments and handover records.
- All of the records we reviewed for patients on Skylark ward had detailed and up to date risk assessments. Risk assessments were informed by information received from the referrer, considered the person's risk history and were re-evaluated throughout admission. Risks focussed on patients' physical needs and mental health issues, for example self-harm and risks from over-exercising and purging. Steps to mitigate risks were intended to be the least restrictive possible in order to maintain patient safety. Ward staff used a recognised risk assessment tool called MARS MEWS, which is an early warning scoring system for inpatient eating disorder units. All patients were initially classified as high risk on admission, due to the physical risks associated with eating disorders. Within a week of admission, a multi-disciplinary team review took place and then risk management was individually care planned. Sometimes, patients who were physically unwell were put on one to one observations, which appeared appropriate.
- On Sandpiper ward, each patient record we reviewed contained a fully completed risk assessment. The multi-disciplinary team reviewed these weekly at a minimum, adjusting levels of observation as appropriate. Staff also reviewed assessments following incidents or deterioration in mental state and adjusted observations accordingly.
- Blanket restrictions were used only when justified. On Sandpiper ward, for example, blanket restrictions were in place to maintain the safety of the patients on the ward. This included a list of prohibited items and there was an associated requirement for staff to search patient belongings at admission to ensure none of those items were brought on to the ward. The ward did not search patients returning from time off the ward as a matter of course, but only searched if there were concerns that prohibited items were being brought onto the ward. If necessary, staff could use a 'wand' to check for secreted metal items. The ward manager confirmed that staff did not receive specific search training, so staff did not 'pat down' patients on their return. Similarly, Skylark ward had a search policy for when patients came back onto a ward from leave. Carers and patients described the searches as discreet, because they were completed in the privacy of patients' rooms.
- Informal patients on the two adult wards were free to leave the hospital at will. The only exception to this was when an informal patient was considered by staff to be at significant risk if they left the hospital unescorted. On Sandpiper ward, for example, the ward doors were normally left unlocked; however, the ward had a policy to lock the door if a patient presented as a particular risk from absconding. We saw that this policy had been implemented following an incident the night before the inspection. Clear signage advised informal patients of their right to leave the ward, and staff confirmed they had spoken to patients before the decision to lock the door had been made.
- The provider had policies to cover observations. All patients were allocated a level of observation dependent on their level of risk. These were regularly reviewed and reduced as soon as appropriate to minimise restrictive practice. On Sandpiper ward, we saw evidence that some staff members did not randomise the times they checked on patients, which was against provider policy. We fed this back to the hospital managers at the time of inspection, who assured us they would take steps to ensure staff followed the correct procedure in future.
- At our previous inspection, we identified serious concerns in relation to the provider's systems and processes for assessing and managing risks to patients and staff. This included the use and monitoring of both restraint and rapid tranquilisation. There had been an upward trend in the use of restraint on Kingfisher ward, and the systems and plan to address this were not effective at that time. We found there had been significant improvements made since our previous

# Detailed findings from this inspection

inspection. Kingfisher ward had been a particular concern, but a permanent specialist CAMHS consultant and new CAMHS nurses, employed since the previous inspection, had contributed to a significant decrease in use of both rapid tranquilisation and restraint. There were now much lower levels of aggression in the patient group, and there had been a corresponding fall in recorded episodes of both restraint and rapid tranquilisation. According to the provider's incident records, there had been 45 incidents which required staff's physical intervention in the first six months of 2016, but only 12 in the second half of the year. Similarly, we found nine incidents where rapid tranquilisation had been used in 2016. These incidents had all happened in the first four months of the year; and six of them had involved the same patient, who had since transferred to a higher dependency unit, where their needs could be met. There were no recorded incidents involving the use of rapid tranquilisation since the end of April 2016. The provider's incident records showed that restraint was rarely used on the ward, as there had been 13 incidents that required staff's physical intervention in the first six months of 2016 and none in the second half of the year. Rapid tranquillisation had last occurred on the ward several years previous. Forms reviewed for incidents on Sandpiper ward showed that staff used restraint techniques only following the failure of other de-escalation strategies. The records seen also indicated restraint was rarely used, and the method of restraint training that staff received did not use prone (positioned face down on the floor) restraint techniques. There were 19 incidents that had required staff's physical intervention recorded in the first six months of 2016, and nine in the second half of the year.

- Staff showed a good understanding and knowledge of safeguarding procedures. Staff on Kingfisher ward had a good understanding of safeguarding and knew whom to contact if there were any safeguarding concerns. Specific safeguarding issues relating to family or visitors were clearly set out in care records and handover sheets. Parental responsibility, and whether a child was subject to a child protection order, was also recorded. Staff on Sandpiper ward were able to outline the safeguarding process. We were shown a safeguarding flow-chart in the nurses' office, which helped staff to consider what actions to take in certain cases. They also reported directly to the Nurse-in-Charge when they were concerned about safeguarding issues. A nurse on

Skylark ward gave us a recent example of a safeguarding concern that had been reported to the local authority safeguarding team. There was a centrally held safeguarding log, and designated safeguarding leads for child and adult safeguarding, plus deputies for each. Safeguarding alerts were usually generated automatically from the electronic incident log if staff had recorded that there were safeguarding concerns, but safeguarding leads also escalated incidents if they considered it necessary. The safeguarding leads attended the independent hospital forum (quarterly) and the provider's own regional safeguarding meeting.

- There were effective systems in place for the safe management of medicines. The provider used a pharmacy services provider to support staff regarding medicines management. Medicines were transported and stored appropriately, and staff completed drug charts appropriately when they administered medicines. Patients' medicines were reconciled at admission to ensure doctors prescribed the correct items. Staff had not completed fridge temperature checks between four to six times in each of the previous four months. This meant there was a risk that medicines requiring refrigeration may not have been stored at the correct temperature, which would affect their efficacy.
- There were safe procedures in place for children visiting the wards, and patients were encouraged to have visits with children off the ward, utilising the ward's family room or other facilities in the building.

## **Track record on safety, reporting incidents and learning from when things go wrong**

- At our previous inspection, we had identified serious concerns in relation to the provider's systems for reporting incidents and learning from when things go wrong. We took separate enforcement action against the provider regarding those issues. We then returned to the hospital shortly after our inspection visit to check on the provider's immediate actions in response to our findings. We found the provider had responded positively and was taking steps to address the issues we had raised. At this inspection, we found the improved systems and procedures for reporting and learning from improvements had been effectively embedded.
- All incidents were now recorded individually as single entries by staff, each with their own incident report. All logged incidents were checked daily by nurses and weekly by ward managers. All staff had now received

# Detailed findings from this inspection

training in the incident system. 'Learning from experience' memos were sent out to all staff by email, with voting buttons, so managers knew that staff had read the email. We were shown a staff aide memoire for incident recording and reporting, explaining what, how and when to report, which incidents are safeguarding and which are notifiable. Incident data provided after our visit showed that there had been considerable improvement in how staff completed incident forms, which were generally now more complete, detailed and accurate. Staff told us they now found the electronic incident form simple and easy to complete. They were able to describe exactly how incidents should be classified and captured on the system. We became aware of a number of recent incidents during the course of our inspection, and were able to check and confirm that there were appropriate incident forms relating to each incident.

- Providers have a statutory duty to notify the Care Quality Commission (CQC) of a range of events or occurrences. These include, for example, allegations of abuse and incidents reported to or investigated by the police. At our previous inspection, we identified that the provider had not notified us of a number of such incidents. The provider has effectively addressed this situation, and we have the appropriate assurance that their systems and processes work effectively to ensure we now receive all notifications as required.
- Staff told us they met together for discussion after serious incidents, and that debriefing sessions were organised for them after such events. After logging an incident, feedback was received through an acknowledgement email, which detailed the incident and actions taken to address or learn from it. Feedback was also disseminated through staff meetings and handovers. We saw meeting minutes that confirmed that such feedback and learning from incidents took place in staff team meetings and weekly 'learning from experience' meetings. Staff were given a mini-debriefing if required, post-incident, and then a detailed debriefing took place several days later. A senior manager hosted this if the incident was serious. One staff member mentioned that while the debrief following incidents was supportive and useful, it didn't always take place at the right time, meaning staff involved in an incident would sometimes have to come in on a leave day to attend the debriefing. They felt it would be better if the debriefings were offered at a time convenient to staff

and when they are on shift. Managers confirmed that following a serious incident staff were offered a range of support, which included the input of external agencies or the provider's psychologists where appropriate.

- We saw evidence of change having been made because of feedback and learning following incidents, and were given an example of a recent incident involving the disposal of sharps. This was documented as an incident and a new system had been implemented to prevent a reoccurrence. Management had informed staff of this by email and at the team meeting. We saw informative posters were displayed in relevant ward areas to reinforce the new process to staff. We saw other incidents were discussed in the weekly 'learning from experience' meetings and improvements to processes and practice as a result.

## Is the Priory Hospital Southampton effective?

**By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.**

### Assessment of needs and planning of care

- Care records showed that appropriate staff carried out comprehensive assessments, at or soon after patients' admissions to the hospital. Doctors and senior nurses carried out assessments of patients, and we saw that those staff completed care plans and risk assessments. The assessments included mental state and physical health, risk and future needs, and included the initial observation required. For informal patients, the observation level was determined with their agreement. On Kingfisher ward, admission aims were discussed with young people and their family. Those aims were then reflected in the patients' care plans, and incorporated by staff into wider ward activities, such as education and occupational therapy.
- Care records showed that patients had undergone physical examinations and that there was ongoing monitoring and care of physical health problems. On Kingfisher ward, staff monitored and recorded physical health as required. In relation to young people with identified concerns with eating behaviours, additional weight, food and fluid charts were completed. Patients on Skylark ward were weighed twice weekly, and physical health checks were carried out at that point. The six care plans we looked at each had evidence of

# Detailed findings from this inspection

ongoing physical monitoring and care. On Sandpiper ward, we saw that staff carried out physical health assessments of patients on admission, and these informed appropriate subsequent physical health interventions.

- We looked at 17 patients' care records in total. Care plans were generally up to date, personalised and recovery oriented. However, although we found improvement since our previous inspection, we found there remained some variance in quality of care records across the three wards. On Kingfisher ward, care of young people took place within the care programme approach (CPA) framework. Care records were detailed and had been updated regularly to reflect clinical need. Patients had a comprehensive assessment, incorporating mental health, medication, physical health and psychosocial needs. Similarly, all care plans we looked at on Skylark ward were up to date, personalised, and holistic and recovery focused. On Sandpiper ward, we found examples of care plans, which staff had not updated since the admission date, even when it was apparent that the patient's circumstances and presentation had changed. Staff told us that they felt that workload and time pressures affected their ability to write and maintain comprehensive care plans, and that the quick turnover of some patients caused issues. We raised this with the ward manager, who confirmed that there were changes planned for the care planning process in order to improve the situation. An audit carried out by the provider in January 2017, had already identified a number of improvements were required to some patient care plans. This included that care plans for patients on Sandpiper ward did not have sufficient evidence of patient involvement.
- Care plans and confidential records were stored securely and available for staff use as appropriate. The provider used a computerised system to store records, with a paper file available for staff to store some documents in. Staff were clear that they regarded the computerised file as the primary source of information for supporting patients. We saw on Skylark ward how staff scanned and entered onto the relevant part of the electronic patient record any information received on paper, such as referral documents. Essential patient paper records were stored in files in a supervised or locked office. There was a paper document for recording

checks of pressure relieving mattresses. The policy was for staff to check these twice daily, but we found gaps in the checks. The charge nurse was already aware of this and had introduced measures to address it.

- We found a specific issue with staff's limited access to computers on Skylark ward. Staff raised this as an issue, and we witnessed there appeared to be insufficient computers available for staff to access them whenever they needed. Staff managed by liaising with each other and through good will, but it appeared to be causing significant stress as the ward office was busy and computers were not always available at the right time. There were two additional computers available downstairs, but staff told us they were not always free to go down to access these. The hospital managers told us that there were plans to build a new nursing station on Skylark ward, which would improve staff's access to computers.

## Best practice in treatment and care

- Wards worked within National Institute for Health and Care Excellence (NICE) guidelines in respect of the prescribing and management of medication. Medication records demonstrated consultants and doctors followed appropriate NICE guidelines and prescribed treatments within British National Formulary limits.
- Patients on the three wards received a wide variety of different psychological therapies. All patients accessed individual therapies, and there was an active group therapy programme. Therapies patients could access included trauma therapy, Gestalt therapy, cognitive analytic therapy, cognitive behavioural therapy, art therapy and drama therapy. Patients were also able to access the support of a mindfulness, yoga and body image therapist. Patients on Skylark ward told us there were more sessions that are therapeutic at the hospital than at other services they had been to, and that their days were structured around activities and therapy sessions, which helped them to focus their mind on positive activities and well-being. We found there was a good range of interventions available on Kingfisher ward and a strong emphasis on a recovery model, with proactive engagement with young people to help them identify emotions and coping strategies, and to debrief after a crisis. Young people had an allocated keyworker, whom they met for regular one to one sessions. There was a well-balanced individualised timetable of activities, education and therapeutic interventions.

# Detailed findings from this inspection

## Skilled staff to deliver care

- Ward teams were multi-disciplinary and had the input of a full range of staff. This included occupational therapist, social worker, doctor, nurse, psychologist and therapists. Wards were also able to access the support of a dietician, a fitness instructor and activities co-ordinators. A pharmacist from the hospital's supplying pharmacy visited the wards weekly. Staff spoken with all had a clear understanding of their roles and responsibilities.
- We reviewed the service's staff training figures, which showed staff were up to date with the majority of their core training. We saw that the only areas of training for which a noticeable number of staff were overdue were 'breakaway' and the prevention and management of violence and aggression, both essential for staff to be able to support safely patients with challenging behaviours. About a quarter of front-line staff were out of date with their training in these areas. We raised this with the hospital's managers at the time of inspection. They were aware, and all staff who were out of date with this training had already been allocated dates to complete the training.
- Staff were able to access a broad range of in-house training and additional specialised training. On Skylark ward, for example, all multi-disciplinary team staff were encouraged to attend an eating disorder training programme. This was to extend staff's eating disorder knowledge and skill base to improve practice. However, staff also told us there was additional specialised training they wanted or needed to be able to carry out their roles more effectively. Staff on Kingfisher ward told us they would like additional training in dialectic behaviour therapy. On Sandpiper ward, although staff did not refer to specific training needs, they did raise with us that at times they did not always feel sufficiently trained or prepared to support the acuity levels and complex needs of some of the patients admitted to the ward under the block contract with the local NHS trust.
- Staff at the three wards told us they received sufficient supervision and felt well supported in their roles. On Skylark ward, all staff had been allocated a supervisor and were expected to access monthly supervision. Although not recorded as formal supervision, reflective practice seminars were organised by senior staff for when specific issues arose, which allowed all the ward staff team to come together to explore an issue. In

addition, staff told us informal supervision was always available. On Sandpiper ward, in addition to formal supervision, an external reviewer and consultant was on-site monthly to provide external supervision. Staff spoke highly of the consultant and positively of the support given, and appreciated that managers ensured they had time set aside to see them when they were on-site. All staff spoken with on Kingfisher ward told us that they felt well supported by their managers and although formalised monthly supervision was not always consistently undertaken, there was ad-hoc supervision as and when they needed it.

- Each ward had regular staff meetings, either weekly or fortnightly. We saw minutes and confirmed that these were taking place monthly. Agendas including sharing of learning and updates for staff. Specific topics covered had included changes that had taken place at the hospital with the CAMHS and eating disorder services. A staff forum took place once a month. Although designated staff ordinarily represented staff on each of the wards, these were also open for all staff to attend.

## Multi-disciplinary and inter-agency team work

- Nursing staff met daily for handover at shift change on each of the wards. On Skylark ward, there was a multi-disciplinary team (MDT) handover each morning from the nurse in charge to therapists. Handover sheets were clear and detailed. They reflected the key risks, needs and observation levels for each patient.
- There were regular and effective multi-disciplinary meetings on Kingfisher ward. There were weekly multi-disciplinary ward rounds and regular care programme approach (CPA) and discharge planning meetings. Care records were updated during the ward rounds. Similarly, on Sandpiper ward, consultants led multi-disciplinary meetings each week. The consultant contracted to manage the beds block-booked by the local NHS trust confirmed that they found it useful in MDT meetings to have the allocated liaison person from the trust involved. Also included in the meetings were other members of the multi-disciplinary team, such as ward staff and psychologist.
- Ward staff worked effectively with other teams involved in the individual's care. On Skylark ward, for example, weekly update reports were sent to the patients' community mental health teams (CMHTs), detailing their care and progress. These included information from both the multi-disciplinary and nursing teams. CMHT

# Detailed findings from this inspection

representatives also usually attended patients' CPA meetings. The consultant told us that, because of the block contract with the local NHS trust, the potential length of stay for patients had reduced due to better liaison with external professionals. They said they were able to contact more easily local care coordinators, and patients' consultants from the community or other inpatient units had visited the hospital to review their clients and attend the MDT meeting.

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

- At our previous inspection, we found there were effective systems in place to ensure adherence to the Mental Health Act (MHA). Those systems remained in place at this inspection.
- Staff had received training in and had a good understanding of the act. Patients had access to Independent Mental Health Advocacy (IMHA) as and when required. Evidence was seen that staff explained patient rights under the MHA at admission, or when significant changes in their detention status occurred. The hospital's MHA administrator had processes in place to ensure that this took place, and appropriate attempts were made by staff to revisit rights under the MHA if a patient lacked capacity to understand them initially. The hospital's MHA administrator was available to provide support to staff and ensure adherence to all aspects of the act. We found that appropriate forms were attached to medicine charts to confirm that correct actions to obtain consent to treatment had been followed. Detention paperwork was scrutinised and stored appropriately by the MHA administrator.
- We found consent recorded in the CAMHS records and noted there was reference to Gillick competency where appropriate. Gillick competency relates to children and young people who are under legal the age of consent but deemed capable of consenting for themselves

## Good practice in applying the MCA

- At our previous inspection, we found there were effective systems in place to ensure adherence to the Mental Capacity Act (MCA). Those systems remained in place at this inspection.
- We saw that mental capacity assessments and patients' consent were clearly recorded by staff in patient files. Staff were aware of and able to refer to information regarding the MCA and Deprivation of Liberty Safeguards (DoLS) on the provider's internal intranet. On

Sandpiper ward, we saw that informal patients were asked to sign consent to treatment forms when they were admitted. We saw well-completed mental capacity assessments for patients, which were done when there was an indication that a patient's capacity may be impaired. On one occasion, in line with the act's principles, when a doctor had felt that a patient's mental capacity would improve they had repeated the assessment the next day, which then resulted in a different outcome from the initial assessment. We saw evidence of best interest decisions, made following correct processes. We also saw records of discussions and appropriate consideration given to DoLS concerning a patient, where ultimately the decision was that it was not an appropriate intervention in that instance.

## Is the Priory Hospital Southampton caring? By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

### Kindness, dignity, respect and support

- We observed staff treating people with compassion and speaking to patients in an encouraging, sincere and caring manner. Staff expressed good understanding of the patients in their care, and awareness of how a patient's history was likely to be relevant to their ongoing care and treatment. For example, on Sandpiper we observed staff spoke to patients appropriately and respectfully, and were discreet when discussing individual issues with patients.
- Patients corroborated our positive observations. They said that staff were very caring and supported them at all times in a respectful manner. Patients specifically emphasized that staff were understanding and not judgemental. Patients on Sandpiper ward told us they were given choice, including over food, activities and therapy sessions.
- Patients on Skylark ward told us that they felt supported by staff and, despite their individual treatment regimes at times being challenging, they felt positive about the care provided. Some staff were described as being 'amazing' and as going 'above and beyond' what was expected. However, patients on Skylark ward also said there was a difference between the standard of support

# Detailed findings from this inspection

provided by regular staff and that provided by some agency staff, who they felt were not always understanding of their illness and specific needs and risks.

- Patients on Kingfisher ward told us staff were very caring and respectful. They emphasised that staff were understanding and not judgemental. They told us they had access to their care plans, and were involved in completing them weekly. They said they felt safe on the ward.

## The involvement of people in the care they receive

- Admission processes informed and oriented patients to the ward and service. On Skylark ward, patients told us staff had provided them with an information pack upon admission, and that generally they understood the process of admission. However, some patients said that the admission booklet had too much detail, which meant it was difficult to work out the important things such as what they could bring with them to admission. Patients admitted to the hospital early December 2016, when the eating disorder grew to include rooms on the hospital's lowest floor, said they thought it had been a bad time for admission as both staff and patients had been very unsettled. They told us that as a result the atmosphere had not been as welcoming as it should, and had at times been chaotic. Patients who were already on the ward and lived through the ward change said it was very disruptive, and that they thought the provider had poorly thought it out.
- There was some variation across the three wards, but we saw ways in which patients were involved in the planning of their own care. On Kingfisher ward, young people were actively involved in developing their care plans and crisis management plans, and had all received copies of their care plans. They told us they were involved in updating their own care plans weekly. Similarly, on Skylark ward patients told us they were involved in determining their own care as much as possible; however, they also acknowledged that due to the nature of their illness, the treatment often was part of a regime that they had to follow and therefore there were fewer choices available to them. Staff on Skylark ward emphasised to us the importance of regularly checking with patients that their care plans remained relevant to them.
- On Sandpiper ward, patients attended ward rounds, care programme approach meetings to review their care and Mental Health Act tribunals. However, although patients told us the care they received was exemplary, the majority of patients spoken with reported that they had not been involved in their care planning, nor had they received a copy of their care plan. There was minimal documented input into care plans by patients, and it was inconsistent as to whether patients had signed or received a copy of their care plan. Only two out of seven patients spoken with told us that they had received a copy of their care plan; and one of those patients' care plans had been completed and shared with them the day before our inspection, after they had been at the ward for two weeks.
- We saw how the service supported patients to maintain their own independence. On Skylark ward, for example, patients were able to choose to attend activities from the programme and had a weekly meeting with their dietician to plan their menus. Staff supported patients to access independent advocacy input, and we saw evidence of advocates' involvement and support for patients on each of the wards. Advocacy input had increased considerably in the previous 12 months, and 46 different patients, across a range of ages, had received advocacy support between 01 October and 31 December 2016.
- We saw evidence of the appropriate involvement of families and carers. We spoke with parents of a patient on Skylark ward, who told us they had both attended the admission meeting. At the meeting, staff had given them a contact number and invited them to phone at any time, should they have any concerns or require any further information. Both said they felt involved with their relative's care. On Sandpiper ward, patients told us they could decide whether staff share information with their families and carers, and those carers could attend meetings if the patient agreed.
- Patients were able to give feedback on the service they received. On Skylark ward, patients were able to feedback about the service in a number of ways in. These included regular one to one meetings with a named member of staff, and weekly community meetings with staff to discuss general issues or concerns. On Kingfisher ward, daily morning meetings allowed patients to reflect on group dynamics on the ward, and provided an opportunity to feedback on any issues. Similarly, weekly community meetings took place on Sandpiper ward, to allow patients an opportunity to raise concerns about the care they

# Detailed findings from this inspection

received and suggest possible changes to the service. Upon discharge, patients on the three wards were asked to complete a full survey about the service they had received. We saw returns for the surveys that the provider had sent out to patients between 1 November 2016 and 31 January 2017, and all contained positive responses about the quality of care and therapies provided.

- Patients were able to get involved in decisions about their own care and the wider service provision, which included involvement in the recruitment of staff. We saw evidence of recent patient involvement in interviews. Patients had been able to attend staff interviews, and to set some of the interview questions if they had felt unable to attend the interview in person.

## Is the Priory Hospital Southampton responsive to people's needs?

**By responsive, we mean that services are organised so that they meet people's needs.**

### Access, discharge and bed management

- On Sandpiper ward, staff were clear that people were only ever discharged or moved at appropriate times of the day. Furthermore, discharge from the ward was generally not delayed for anything other than clinical reasons. We did see evidence of a delayed discharge, but this had been due to difficulties finding a care coordinator and housing for a patient who was of no fixed abode. Although largely beyond the provider's control, staff stated that it was not always easy to find a bed on a psychiatric intensive care unit if a person required more intensive care. They told us this could sometimes be problematic and that a transfer might be delayed, meaning that a patient would be inappropriately placed until a bed was identified.
- On Skylark and Kingfisher wards, we found a similar situation in relation to admission to and discharge from the service. Patients retained a room throughout their treatment until discharge. Admissions and discharges of patients were well planned by staff, so that they occurred only at arranged times. We found no evidence of delayed discharge when speaking to staff and patients, and staff told us that they would only discharge patients according to the clinical need. Staff on Kingfisher ward told us that information received in referrals sometimes lacked the detail required at admission; however, senior clinical staff were able to

make decisions about patient admissions and transfers. On Kingfisher ward, the staff team had regular admission and discharge meetings with the NHS England caseworker who commissioned beds, and we found that there were clear admission and discharge pathways.

- Following changes to the size of the eating disorder service, the provider had taken an additional seven beds from the CAMHS service on the lowest floor of the hospital and transferred them to Skylark ward. Both staff and patients described the addition of the new beds as having been challenging and problematic. However, eating disorder patients who were at higher risk retained beds on the top floor of the hospital, on the original Skylark ward. Staff told us they had not had to move any patients downstairs prematurely in order to make room for someone with a higher level of risk. They also said that the hospital's managers had respected their clinical judgement regarding if and when to move patients, even if at times this had led to not all the beds in the eating disorder service being filled with patients.

### The facilities promote recovery, comfort and dignity

- The environment on each ward was clean and comfortable, and the furnishings and decoration were in good condition throughout. Each ward had a range of different rooms and equipment to support treatment and care. This included rooms for interviews and therapies, clinic rooms for examinations, quiet rooms and larger communal rooms for group activities.
- Quiet areas were available on the wards and in the hospital where patients could meet visitors and make private calls. Although patients generally chose to take visitors to their rooms, if required patients could request a room to meet visitors in and the shared multi faith room doubled as a family visiting room.
- At our previous inspection, we identified a specific problem in relation to the emergency alarm system at the hospital, which caused disruption by going off loudly and repeatedly on Kingfisher ward. This was related to incidents in other parts of the hospital outside the ward, but was to alert staff on Kingfisher ward so they could attend to provide assistance. We found the alarm system was disruptive, and not conducive to creating a calm and therapeutic environment. At this inspection, we found the provider had installed a new

# Detailed findings from this inspection

staff alarm system that operated effectively to identify to ward staff exactly where in the hospital an emergency was taking place without causing the disruption to the patients of the previous alarm.

- The majority of patients on Sandpiper and Skylark wards were informal and so had access to the grounds surrounding the hospital. Due to the nature of their illnesses, staff escorted most of the patients on Skylark ward if they went out in the grounds. As we found at our previous inspection, due to specific safety concerns related to many of the young people on Kingfisher ward, there was limited access to outside space for those patients. There was a separate enclosed outdoor space where they could go under staff supervision, but young people were not able to go out in the enclosed unit garden or the hospital grounds unescorted.
- The feedback received from patients during the inspection was that the food provided was of good quality. Patients on Sandpiper ward spoke positively about dinner arrangements for visitors, which allowed them to enjoy their dinner with patients in the restaurant. Patients found that this encouraged their own appetite to a healthy level and brought a sense of normality to their routine. One patient on Kingfisher ward told us that staff had initially struggled to meet their specific dietary needs; however, they had met up with a dietician who had formulated a plan around the patients' choice of foods to encourage a good intake of food. Patients on all wards were able to access hot drinks and snacks whenever they wanted them.
- Patients generally had access to a broad range of activities. On Sandpiper ward, patients spoke highly of the activities coordinator and said that they did an amazing job at keeping them entertained and engaged during the day. One patient told us that he did not know how to cook, and to encourage his independent living for when he was discharged back home, he was now learning to cook. The activities coordinator had developed a tailored plan for him to learn to prepare the dishes he wanted. Patients told us the weekly day trips gave them something to look forward to and they really enjoyed them. However, while the activities coordinator did a great job during the week, patients told us that fewer outings and activities took place on the weekend, so they tended to be less structured and consequently more boring. The activities coordinator subsequently informed us that in response to staff and patients'

concerns, they had started to work three Saturdays a month to help improve the situation on weekends. This meant that patients were still without a dedicated activities coordinator one day during the week and on Sundays, so there was the potential for the same problem to manifest on those days. Patients on Kingfisher ward told us that the activities at the ward were great, and that they followed a structured daily plan, which helped to keep their mind away from negative thoughts. There was good access to a selection of activities on the ward, such as games and DVDs. The occupational therapist had organised voluntary work opportunities at a local farm, and there was a reward system in place for group trips out. However, similar to Sandpiper ward, patients on Kingfisher ward told us weekends were less well structured, and patients reported feeling bored on these days. On Skylark ward, the activities programme was designed for seven days a week; however, patients were unclear as to whether all activities ran as timetabled throughout the weekend as some were nurse led. Trips out were a popular activity at the weekend, if patients were well enough to participate. These often involved a trip to a coffee shop, place of interest or general shopping for patients. Patients spoke very highly of their new part time activities coordinator, who had been on the ward for the previous couple of months.

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

- Wards had been adapted to support mobility and accessibility for disabled people. This included flat surfaces and ramps for wheelchair users and disabled adapted toilets. Bathrooms had necessary hoisting equipment and adapted baths. Outdoor spaces were flat and pathways wide enough for wheelchair access. On Sandpiper ward, a bedroom had been adapted for the use of patients who used a wheelchair.
- At our previous visit, we identified a specific concern in relation to the location of Skylark ward, which was on the top floor of the building and accessible only by stairs. Due to the nature of the ward, which is the treatment of eating disorders, there was a risk that patients might use the stairs to excessively exercise or, conversely, may actually become too unwell to use the stairs. Senior staff acknowledged our concerns at the time of the previous inspection, and suggested that the eating disorder service's form and location were likely to change as part of a broader future re-evaluation and

# Detailed findings from this inspection

redesign of service provision at the site. We found the situation remained the same at this visit.

Commissioners, who understood the service's physical limitations, rarely made referrals for disabled patients to the eating disorder service; and the provider had other services that were able to accommodate disabled patients effectively. However, there remained an issue regarding patients who became unwell whilst on the ward and required the use of a wheelchair, as they would have no means of going outside due to the absence of a lift. Lack of wheelchair access also prevented disabled visitors from visiting patients on the upper Skylark ward who were unwell, as neither would be able to negotiate the stairs. Further, the weighing scales remained on the hospital's first floor, which meant that patients had to be supported down the stairs twice a week by staff for weighing, which was an essential part of their treatment regime.

- At each of the wards, there was a range of information provided for patients. This included information on different conditions and treatments, patients' rights, local support projects including advocacy, and how to make a complaint if they were not satisfied with the service they received.
- Staff were able to access the support of interpreters to meet the communication needs of patients for whom English was not the primary language. Patients could access appropriate spiritual support if they wanted it. There was a multi-faith room available for patients on all wards to use. A Chaplain visited the ward for a short visit each week. Staff told us they would escort patients to places of worship if required. If a patient required the support of a religious leader specific to his or her own faith, such as an imam or rabbi, the provider was able to arrange this.

## Listening to and learning from concerns and complaints

- Although none of the patients we spoke with had any serious complaints about the care they received, they knew how to complain and felt able to do so if they ever wanted to. Patients on Kingfisher ward told us they had seen posters around the ward about making a complaint. They also had regular access to an independent advocate. Staff provided details to patients and their carers, on admission, about how to access the advocacy service. All of the patients we spoke with on Skylark ward and their carers said that they would raise

any issues or complaints firstly with staff, either informally as it occurs or in one-to-one meetings.

Patients were also aware of advocacy services that they could talk to for support making a complaint if they had issues.

- Staff knew how to deal with complaints. They told us they would try to resolve minor complaints directly with patients, but would support patients to write down complaints that are more serious so they can then pass them on to senior managers to be responded to formally and according to the provider's complaints procedure. We saw evidence in minutes to confirm that staff discussed individual complaints and learning from complaints at weekly 'learning from experience' meetings. Staff gave us examples of improvements made following complaints from patients. For example, there had been complaints about the lack of lounge for the new eating disorder beds on the downstairs ward. This had been difficult for patients, as they had to go upstairs to use the lounge on the top floor or stay in their bedrooms. It had also made it difficult for staff to oversee and care for patients. Because of the complaints from patients' and staff, the provider had converted a bedroom downstairs into a lounge.

## Is the Priory Hospital Southampton well led?

**By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.**

### Vision and values

- Staff on Sandpiper ward told us they had met senior managers, but their interaction was primarily limited to the ward managers and hospital senior team members rather than the Priory Group's executive team. Staff emphasised that care was at the centre of everything they did, and many of them felt a sense of pride for the standards of care they were providing. Similarly, staff on Skylark weren't able to tell us a great deal about the provider group's vision and values, but were united in their commitment to providing quality care and support to the individuals in their care. Ward managers were able to give us detail about the organisation's values and vision, and believed that their teams worked to

# Detailed findings from this inspection

those values when supporting patients. Ward and hospital managers understandably had more contact with the provider's senior management team, and found them approachable and supportive.

## Good governance

- The provider's systems worked effectively to ensure staff were kept up to date with their mandatory training and received regular supervision. Despite ongoing nursing staff shortages, the provider made sure sufficient numbers of staff of the right grades and experience covered shifts. Ward and hospital managers were highly thought of by their teams and were able to lead with appropriate authority.
- As discussed above, we had identified serious failings at our previous inspection in relation to the provider's recording, monitoring and reporting of incidents. At this inspection, we found the provider responded well and had taken all necessary steps to address those failings. Similarly, at our previous inspection we also had concerns related to the levels and monitoring of both rapid tranquilisation and restraint. We found the provider had taken all necessary steps to address those concerns. Restraint and rapid tranquilisation were now being effectively recorded and monitored, and a change of focus and practice had resulted in a sizeable drop in their use.
- We reviewed minutes to a range of meetings that formed the provider's oversight and clinical governance of the hospital. Monthly clinical governance, medicines optimisation, senior management team, and health and safety meetings were all scheduled to take place on the same day, which made it easier for all relevant staff to attend each of the key governance meetings. Minutes evidenced that these were all documented. Weekly 'learning from experience' meetings fed directly into the clinical governance meeting, and included safeguarding, complaints, serious incidents, restraints and reviews of high-risk patients. The meeting had an associated action plan, with owners for all actions.
- Ordinarily, the hospital director or director of clinical services had responsibility for adding items to the provider's risk register. We saw the up-to-date register, which had several entries including specific concerns related to the environment, such as outstanding ligature works to be completed.
- A range of regular audits was carried out across the hospital and on the individual wards. These covered key

areas of service delivery and quality such as safety and cleanliness of the environment, provision of patient information, health and safety, and care records. Different quality 'walk rounds' took place regularly on each ward, and these covered patient experience, documentation and the environment. These were not uniform, and audits differed in quality and completeness according to which member of staff had carried them out. For example, one such walk round audit had identified a number of gaps and errors in care records checked, but there were no associated actions to be taken to address the findings or dates for when they would be addressed. The same audit, carried out by a different staff member on another date, was very clear and detailed. We raised this with the hospital's managers at the time of inspection. They were already aware of the lack of consistency and assured us they were taking steps to make sure all staff completed audits and quality checks to the same standard.

## Leadership, morale and staff engagement

- The outgoing hospital director, who remained its registered manager at the time of this inspection, had been in post since September 2015. Prior to their arrival, the hospital had several different directors over a short period; a lack of continuity of leadership, which had contributed to the issues with governance we had found at our previous inspection. During their time in post, the outgoing hospital director had overseen a wide range of improvements at the hospital, leading the effective action taken to make essential changes. They had recently transferred to another of the provider's hospitals, but were available on-site for this inspection. An interim hospital director, who had worked in a senior capacity at the service for several years and had worked closely with the outgoing director through the change and improvements, was also in post. The provider had made a permanent appointment to the post, but they were yet to take up their position at the time of our inspection.
- Staff knew how to use the whistleblowing process and felt able to raise concerns without fear of victimisation. Staff told us that they raised concerns freely and openly when at staff meetings or in supervision. For example, staff on Sandpiper had raised with managers their concern that staffing levels were not sufficient due to an

# Detailed findings from this inspection

increase in the acuity of patients on the ward. In response, the provider introduced an extra member of staff, and that increased staffing level continued at the time of our inspection.

- Figures supplied to us by the provider indicated that the staff sickness rate remained low, at less than 2% monthly, on average, for the previous 12 months. Staff turnover remained high, but the provider was conducting exit interviews with all leavers in an effort to understand why staff wished to leave and whether there were changes or improvements they could make to retain them.
- Staff morale had been affected in recent months, by changes to the wards and individual service sizes due to commissioning and contract changes. There had been a temporary six-month change of service, from November 2016, with a reduction from 12 to five CAMHS beds on Kingfisher ward. The seven beds had been transferred over to the eating disorder service, which had a corresponding increase from 11 to 18 beds for the same period. The provider and main commissioner of the service, NHS England, had made the decision, as there had been a reduction in referrals and demand for CAMHS beds but an increase in the need for adult eating disorders beds. Staff on both Kingfisher and Skylark wards told us they felt they had not been consulted properly or involved fully in the decisions around this change. There remained some uncertainty among Skylark staff as to what would happen with the numbers of beds going forward, which had led to questions as to whether they would be able to complete all patients' treatment or have to move some of them on when the number of eating disorder beds reduced again. We raised our findings with the hospital's managers at the time of the inspection. We saw evidence to show that there had been communication with staff teams during the changes, but they also acknowledged that the process and communication about the changes to services could have been handled better. The provider subsequently sent formal confirmation that the services would revert to their previous form and size at the beginning of May 2017. We were also given appropriate assurance that this had been communicated to all staff at the hospital.
- Staff morale on Sandpiper ward had also been affected by changes to the service, brought about by the commencement of a block contract for beds from the local NHS trust. Staff told us this contract had resulted in an increase in the overall acuity of patients on the ward, but that staffing had initially not been adequate to cope with this. However, staff fed back that the general morale on the ward had improved a lot in recent weeks; largely because they felt they had been listened to, as the provider had increased staffing levels in response to their concerns. Most of the staff we spoke with told us they were happy to be working on the ward. Staff on Skylark ward told us morale had been poor at the time of the ward changes, but had improved recently and the team was now working well.
- Staff on Kingfisher ward were proud of improvements at their unit since our previous inspection, but felt that there had not been sufficient recognition from the provider for the improvements they had helped to bring about.
- Staff on each of the wards told us their immediate managers were supportive and listened to them. Staff had appropriate opportunities to feed back on services and input into service development, through regular staff meetings and suggestion boxes. Staff team away days took place annually. Staff described the hospital's senior team as responsive and open to suggestions for improvements to services, such as how best to manage beds or maintaining optimum staffing levels. Ward managers told us there was scope for their own leadership development. Regarding their personal development, staff told us that managers responded quickly and positively to support their requests for additional training and development. For example, one member of staff had undertaken training to become a phlebotomist, and others had received specialist training in eating disorders.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should ensure that there are sufficient staff working on Kingfisher ward to be able to escort all patients, at all times, whenever they want to go outside.
- The provider should ensure that staff on Sandpiper ward are sufficiently trained to support the acuity levels and complex needs of all patients admitted to the ward.
- The provider should ensure the standard of support provided to patients on Skylark ward is to the same standard whether provided by agency or permanent staff.
- The provider should ensure that all patients on Sandpiper are fully involved in the planning of their own care.
- The provider should re-evaluate the suitability of the top floor location of the eating disorder service.
- The provider should ensure that staff receive appropriate recognition for the improvements they have helped to bring about at the hospital.

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.

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

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