The Priory Hospital Ticehurst House

Quality Report

Ticehurst
Wadhurst
Tel: 01580 200391
Website: www.priorygroup.com

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

Ratings

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

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

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

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 Ticehurst House as **requires improvement** because:

- The mixed gender accommodation on Highlands ward was not meeting guidance on gender segregation.
- There was no defibrillator on the Lodge. Response time to an emergency drill was well in excess of Royal College of Psychiatry guidelines.
- Feedback to staff following incidents and safeguarding alerts was poor on the long stay rehabilitation wards. There were inconsistencies between paper and electronic incident reports on the long stay rehabilitation wards.
- Staff supervision was variable for staff on rehabilitation wards.
- There was a lack of meaningful rehabilitation on Highlands and the Lodge.
- Not all staff on the rehabilitation wards could access computer systems to record and access patient information.
- There was an inconsistent knowledge of the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards on the long stay rehabilitation wards.
- The temperature on the CAMHS ward was cold.
- There were blanket restrictions on CAMHS ward.
- The hospital was undertaking ligature risk audits, however, we found not all risks were identified and mitigated on all wards.

However:

- Medications management throughout the hospital was well managed.
- Patients received thorough assessments on admission to the hospital.
- There was a high compliance with mandatory training throughout the hospital. Staff were also given the opportunity to attend training to further their careers.
- All ward areas were clean, tidy and well maintained. All wards had good access to rooms for activities, visitors, quiet rooms and lounges.
- Patients had care plans that were detailed, holistic, personalised and recovery focused.
- The hospital followed National Institute of Health and Care Excellence Guidelines.
- There was strong multi-disciplinary team working throughout the hospital.
- The hospital offered patients a good range of psychological therapies.
- The child and adolescent mental health service had developed a bespoke programme rolling of training for staff.
- We observed staff interacting with patients in a caring, respectful and responsive manner. All staff we spoke with were passionate and motivated about the service and the patients.
- Patients told us staff treated them well and were responsive to their needs.
- Patients were able to provide feedback on the service and were involved in decisions about the service, for example assisting with staff recruitment.
- Advocacy services were available to patients.
- There was a wide range of information leaflets available to patients in different formats and languages.
- The hospital had a complaints policy. Patients were aware of this and were provided information about how to use it. The hospital had a monthly learning and outcome group where incidents and complaints were discussed.
- The hospital offered a wide range of therapeutic activities to meet the psychological, social, creative and physical needs of patients.
- The hospital had appropriate governance processes from the hospitals senior management teams.

Summary of findings

- Incidents were reported in line with hospital policy on the child and adolescent and acute wards. The Priory Group share learning from incidents at other hospitals to ensure outcomes are disseminated across the hospital group.
- There was a wide range of audits taking place throughout the hospital.
- The CAMHS service were members of the Quality Network for Inpatient CAMHS (QNIC) and were in the process of going for accreditation.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good 	• Staff received regular clinical supervision and told us they found it helpful and supportive. All regular staff had received an appraisal in the last 12 months. • The service offered a wide range of therapeutic activities to meet the psychological, social, creative and physical needs of patients. • The wards conducted their own audits to rate the value of therapeutic activity and monitor the amount and quality of one to one sessions with patients. • The wards were following guidelines by the National Institute for Health and Care Excellence in relation to safe and effective use of medicines to achieve the best possible outcomes for patients.
Long stay/ rehabilitation mental health wards for working-age adults	Requires improvement 	• On Highlands ward the mixed gender accommodation did not meet guidance on gender segregation. • Response time to an emergency defibrillator drill was in excess of Royal College of Psychiatry guidelines. • Feedback following incidents and safeguarding alerts to staff was poor. • Staff supervision was variable. • There was a lack of meaningful rehabilitation on Highlands and the Lodge. • Knowledge of the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards was inconsistent.
Child and adolescent mental health wards	Good 	• The CAMHS wards had developed a bespoke training package called the CAMHS rolling programme. Training was delivered monthly to staff and was specific to child and adolescent mental health. Staff spoke highly of the training.

Summary of findings

- Staff received supervision every month and were up to date with their appraisals.
- Care plans were thorough and holistic. Young people were involved in the creation of their care plans. Young people led ward rounds and were encouraged and supported.
- Incidents were reported in line with hospital policy. Feedback and learning from incidents were provided to staff.
- The CAMHS wards were members of the Quality Network for Inpatient CAMHS (QNIC) and were in the process of going for accreditation.

Summary of findings

Contents

Requires improvement

Priory Hospital Ticehurst House

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units, Long stay/rehabilitation mental health wards for working-age adults, Child and adolescent mental health wards

Summary of this inspection

Background to The Priory Hospital Ticehurst House

The Priory Ticehurst House is a hospital located in East Sussex. The hospital offers inpatient mental health services for young people and adults.

The hospital has two acute psychiatric care units. The hospital has three long stay rehabilitation and recovery units and two children and adolescent mental health units.

The two acute wards are for men and women who require assessment and treatment for mental health presentations. The unit has 23 beds, 16 for females and seven for males.

The three long stay rehabilitation and recovery units had 21 beds.

The child and adolescent mental health unit had an acute tier 4 ward with 13 beds for males and females. The unit also had a high dependency unit for 13 females.

Priory Ticehurst is registered for the following regulated activities: Assessment or medical treatment for persons detained under the Mental Health Act 1983; Diagnostic and screening procedures; Treatment of disease, disorder or injury; Accommodation for persons who require nursing or personal care; Accommodation for persons who require treatment for Substance misuse.

The hospital was inspected in September 2013 and was found to be compliant.

The hospital had a registered manager.

Our inspection team

Team leader: Inspection Manager

The team that inspected Priory Ticehurst comprised five CQC inspectors, a Mental Health Act Reviewer and two specialist advisors; one with a with experience of working in forensic/secure inpatient services and one with experience of working in child and adolescent mental health services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme. The service had been found to be compliant during the previous inspection.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all seven wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 20 patients who were using the service

Summary of this inspection

- spoke with the managers for each of the wards
- spoke with 48 other staff members; including doctors, nurses, health care assistants, allied health professionals and administration staff
- spoke with two relatives/carers of patients
- reviewed six clinic rooms
- carried out two focus groups for staff
- received feedback about the service from one care co-ordinator
- attended and observed three multi-disciplinary meetings
- looked at 38 care and treatment records of patients, including risk assessments and care plans
- carried out a specific check of the medication management on all wards and reviewed prescription charts
- looked at a range of policies, procedures and other documents relating to the running of the service
- reviewed staffing rotas
- reviewed mandatory training records of staff
- undertook two mental health act reviews; and
- looked at cleaning schedules for all wards

What people who use the service say

The patients we spoke with were positive about the staff in all services. The interactions we observed between patients and staff were friendly, compassionate and respectful. Staff responded to patients needs in a calm manner.

Patients told us they felt safe at the hospital. They felt supported by staff who listened to their needs and treated them with respect.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated Priory Ticehurst House as **requires improvement** for Safe because:

- The hospital was undertaking ligature risk audits, however, we found not all risks were identified and mitigated on all wards.
- The mixed gender accommodation on Highlands ward was not meeting guidance on gender segregation.
- There was no defibrillator equipment on the Lodge and response time to a drill was well in excess of Royal College of Psychiatry guidelines.
- Incidents were recorded on individual patient behaviour logs but not being formally submitted as incidents.
- The temperature on the CAMHS ward was cold.

However,

- The hospital regularly used bank and agency staff, however, staff were block booked to maintain continuity of care throughout the hospital.
- Medications management throughout the hospital was well managed by an external pharmacist.
- Patients throughout the hospital were assessed thoroughly on admission.
- There was good compliance with mandatory training throughout the hospital.
- All ward areas were clean, tidy and well maintained.
- Staff knew how to recognise incidents and had a good knowledge of safeguarding.

Are services effective?

Requires improvement

We rated Priory Ticehurst House as **requires improvement** for effective because:

- There was inconsistency in monitoring of physical health on long stay rehabilitation wards.
- There was a lack of meaningful rehabilitation on Highlands and the Lodge.
- There were inconsistencies between paper and electronic records on the long stay rehabilitation wards.

Summary of this inspection

- Not all staff could access computer systems to record and access patient information on long stay rehabilitation wards.
- There was an inconsistent knowledge of the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards on the long stay rehabilitation wards.

However:

- Care plans we reviewed were detailed, holistic, personalised and recovery focused.
- The hospital followed National Institute of Health and Care Excellence Guidelines
- The hospital used recognised outcome measure scales to assess patients.
- Staff participated in regular clinical audits.
- Staff received regular clinical supervision.
- Patients had good access to GPs.
- There was strong multi-disciplinary team working throughout the hospital.
- The hospital offered patients a good range of psychological therapies.
- The child and adolescent mental health service had developed a rolling programme of training for staff.
- Staff demonstrated a good knowledge of individual patients throughout the hospital.

Are services caring?

Good

We rated Priory Ticehurst House as **good** for caring because:

- We observed numerous instances of staff interacting with patients in a caring, respectful and responsive manner
- All staff we spoke with were passionate and motivated about the patients they work with.
- Patients we spoke with told us they were happy about the way staff treated them.
- Patients were able to provide feedback on the service they received at the hospital through regular community meetings.
- Advocacy services were available to patients throughout the hospital .
- Patients were involved about decisions about the service.

However:

- Some patients had a lack of involvement in their care plans on long stay rehabilitation wards.

Are services responsive?

Good

We rated Priory Ticehurst House as **good** for responsive because:

Summary of this inspection

- All wards had good access to rooms for activities, visitors, quiet rooms and lounges.
- Patients had access to outside space.
- The wards all had good input from occupational therapists.
- Adjustments had been made for wheel chair access throughout the hospital.
- There was a wide range of information leaflets available to patients in different formats and languages.
- Each of the wards had access to multi faith rooms. Patients were also offered attendance at church services.
- Patients knew how to raise complaints about the service and were supported by staff.
- Patients we spoke to told us complaints were investigated appropriately.
- The hospital had a monthly learning and outcome group where incidents and complaints were discussed.
- Patients told us the food was of good quality.
- The hospital offered a wide range of therapeutic activities to meet the psychological, social, creative and physical needs of patients.
- The hospital had clear admission policy and checklists for completion .

However:

- The environment on Highlands was not appropriate for people with restricted mobility.
- The clinic rooms on Highlands and the Lodge were both too small to accommodate an examination couch. Patient examinations and tests were routinely conducted in their bedroom.
- There were no rooms allocated for patients to spend time with visitors on the wards. They either used the patient's own bedroom or the activity room on the ward.
- Patients we spoke to on the long stay rehabilitation wards told us that they were not happy with the choices on offer. Some patients told us that they preferred traditional English food and did not like the international dishes on offer. Patients said they were not consulted on the choice of menu and we observed patients choose not to eat the daily menu choice and make their own food.
- Staff told us that they are not given feedback on the outcome of investigations into complaints.

Are services well-led?

Requires improvement

We rated Priory Ticehurst House as **requires improvement** for well-led because:

Summary of this inspection

- Staff knowledge and understanding of the Mental Health Act, the Code of Practice and the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) on long stay rehabilitation wards was poor.
- Supervision for staff was inconsistent on long stay rehabilitation wards. Some staff reported they received monthly supervision sessions. However, other staff stated that they had gaps of more than three months between supervision sessions.
- Not all incidents had been reported appropriately on the long stay rehabilitation wards.
- Staff we spoke with on the long stay rehabilitation wards told us that they do not receive feedback on investigations into complaints, incidents and safeguarding concerns.

However:

- Staff we spoke to were aware of and agreed with the hospitals visions and values.
- The hospital had appropriate governance processes from the hospitals senior management teams.
- Staff were aware of the whistleblowing process and were confident to use it.
- Staff received mandatory training and were given the opportunity to attend training to further their careers.
- Staff were able to input into development of the hospital .
- Staff on most wards were receiving regular supervision and appraisal.
- Although there was a high use of bank and agency staff, the hospital had a work force plan in place and initiatives to encourage recruitment and retention of staff.
- Incidents were reported in line with hospital policy. The Priory Group share learning from incidents at other hospitals to ensure outcomes are disseminated across the hospital group.
- There was a wide range of audits taking place throughout the hospital.
- Morale among staff was high and staff were dedicated to the patient groups .
- Staff told us they felt listened to and had participated in listening events to capture their views.
- Staff told us the MDTs were effective and the views of staff of all grades were valued.
- The hospital had staff notice boards and a staff newsletter to engage with staff.
- The CAMHS service were members of the Quality Network for Inpatient CAMHS (QNIC) and were in the process of going for accreditation.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

We found that the use of the Mental Health Act (MHA) 1983 was good in the service. Mental Health Act documentation reviewed was found to be compliant with the MHA and its Code of Practice.

We carried out a specific review of the MHA on the long stay rehabilitation wards and the child and adolescent mental health wards. The paperwork for all the detained patients on the ward was completed correctly.

Patients capacity to consent to treatment was recorded and assessed on admission and then regularly throughout. Consent to admission, to treatment and an assessment of Gillick competency had all been thoroughly carried out in Upper Court. In Highlands, Lowlands and the Lodge we found that capacity had been assessed on a regular basis, and a detailed discussion with the responsible clinician recorded.

A MHA administrator oversaw operation of the Mental Health Act (MHA) at Ticehurst. The role included scrutiny of papers and reminder systems for renewals and consent to treatment paperwork. The administrator also managed applications and renewals of Deprivation of Liberty Safeguards (DoLS).

Basic training on the MHA, Mental Capacity Act and DoLS was included in the induction for new staff. The administrator had recently delivered a two hour training session on the new MHA Code of Practice. However staff at Highlands, Lowlands and The Lodge all requested training on the new Code of Practice as a priority.

Training records showed that 92% staff had received training in the MHA.

Leave for detained patients was authorised on a standardised form, which was clearly completed with details of conditions and escort levels required. We saw evidence that risk assessments had been reviewed before authorisation, and that copies were offered to patients.

Patients on all wards had their rights explained to them on admission and repeated monthly. Although we were able to find evidence that staff had informed patients of their right to an IMHA we were unable to find any detail about whether any patients had been referred to the IMHA.

A yearly MHA audit was reported to central Priory Healthcare management. In addition, the hospital managers reviewed quarterly reports, and the administrator attended monthly clinical governance meetings to raise any issues of concern.

Mental Capacity Act and Deprivation of Liberty Safeguards

There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) policy.

Staff we spoke with generally demonstrated a good understanding and knowledge of the Mental Capacity Act (MCA) and of the hospital policy. However, some staff we spoke to on the long stay rehabilitation ward had a poor understanding. Despite this 89% of staff at the hospital they had received formal MCA training. Consent to admission, to treatment and an assessment of Gillick competency had all been thoroughly assessed on a regular basis, and a detailed discussion with the responsible clinician recorded.

Where patients were not detained under the Mental Health Act, their capacity to consent to treatment and stay in the hospital as an informal patient had been assessed.

At the time of our inspection there were five patients subject to a DoLS authorisation.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Long stay/ rehabilitation mental health wards for working age adults	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

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

Good

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

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

Good

Safe and clean environment

- Newington Court One and Newington Court Two (ward 1 and ward 2) were part of the Priory hospital, Ticehurst. The building is listed so there are restrictions on how much it could be adapted. As a result the layout of both wards had several blind spots. This meant staff could not always observe all the patients in a clear line of sight.
- Ward 2 and the first floor of ward 1 had closed circuit television in all communal areas to reduce the risk to patients who were out of sight. Closed circuit television monitors were located in both the nurses offices. Staff told us they walked round the wards frequently to further reduce the risks presented by patients being out of sight. We observed staff checking on patient locations throughout the inspection. Staff were not always present in communal areas and relied on closed circuit television, in these areas, to ensure patients were not at risk.
- We identified ligature risk points (places where patients intent on self-harm might tie something to strangle themselves) on both wards. Ligature cutters (for use if patients tried to harm themselves with a ligature) were kept on both wards and checked daily. One member of staff did not know where the cutters were kept. A senior healthcare assistant had completed a ligature point risk assessment, using a recognised tool, and rated all risks as high. This was inaccurate as not all ligature points were of high risk. The ward manager told us they would carry out the assessment annually. It was kept in the health and safety records on ward 1. Ligature risk was on the hospital risk register with an action plan to reduce the risk. The action plan included having a trained security nurse on each shift. During our inspection we were unable to find out what responsibilities the security nurse had, or if any specific training had been provided.
- Both wards offered single gender accommodation. Male patients went into female accommodation to access the smoking area and attend therapy sessions. We observed two members of staff escorting male patients to the female ward. Staff checked the area, to ensure the female patients weren't at risk of having their privacy or dignity compromised, before the male patients were escorted through. This was in line with the hospital's policy around same-sex environments. During our inspection, the hospital maintenance team was creating a men-only smoking area.
- Emergency resuscitation equipment and oxygen were located in each staff office. An automated external defibrillator was located on ward 1. Equipment on ward 1 was checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Staff on ward 2 were not checking equipment. We raised this with the ward manager who told us this had been purchased recently and they were introducing a checking system.
- Patients we spoke to told us cleanliness levels and furnishings were good. Staff carried out environmental

risk checks weekly. Maintenance issues could take time to be dealt with. One patient told us that the taps on his bath had not worked for three weeks and staff had reported the problem.

- Staff carried out infection control audits annually, in line with national standards.
- Call alarms were located around the wards but there were no call alarms in the communal bathrooms, an area with an increased risk of patient falls due to wet surfaces. Staff carried radios so they could respond to incidents in the hospital. Staff reported that the radios often had low batteries. Staff all knew where the chargers were but there was no system in place to make sure the radios were charged regularly. This was a potential risk to patients and staff. All staff on shift had a master key, which they received at the start of their shift. Staff were expected to use a system which kept track of who had the keys. Most staff were not using this system regularly. This could pose a security risk to patients and staff as keys could go missing.
- During the inspection we observed many systems for checking various ward activities. These were kept in different places and we found they were not all used effectively. We escalated our concerns about the radios, keys and checking systems. The manager told us the issues would be dealt with as a matter of urgency.

Safe staffing

- Both wards operated on a ratio of one staff member to three patients on both day and night shifts. One extra member of staff is allocated on ward 1 if patients are occupying upstairs bedrooms. At the time of our inspection the upstairs bedrooms were vacant. The ward manager told us they were able to book extra staff if required and had full support from senior management. The ward manager rotated staff on the wards to help cover sickness and annual leave. Staff had knowledge of both ward settings and patients and were able to give good continuity of care.
- The wards had high levels of staff vacancies resulting in high use of bank and agency staff. Between 1 October 2015 and 15 January 2016, 575 out of 1164 (minimum) shifts had been covered by bank or agency staff. The ward manager told us that agency staff on rolling contracts covered most shifts and that they were familiar with the wards. All shifts had been filled in the same period.
- Bank staff were provided with the same level of mandatory training as permanent staff to provide consistency of the service. Agency staff complete an induction checklist specific to the hospital. Recruitment and retention was identified on the hospital risk register with identified mitigation controls. Senior management were acting on these controls.
- Senior management recognised that finding staff and keeping them was an on-going challenge. They felt that being in a remote area with poor access by public transport was off-putting for staff. They had regular recruitment events around the country and offered their staff a number of benefits, such as paid days off for birthdays and employee of the month schemes.
- We saw from the 14 care records we reviewed that eight patients had received regular one-to-one time with staff. Five patients had no one-to-one time shown in their care records but four of them had been admitted in the previous 24 hours. Staff told us one patient had been refusing one-to-one time. This had not been recorded in their care records and staff were unable to recall the last time it had been offered. Staff on ward 1 were offering one-to-one time more frequently than staff on ward 2.
- Patients told us that escorted leave and ward activities were rarely cancelled. Patients occasionally had to wait for escorted leave and smoking time.
- Care notes showed staff were carrying out regular physical interventions such as blood pressure and blood sugar monitoring. The consultant psychiatrist told us there was enough medical staff available day and night to attend the ward in an emergency. Two junior doctors provide medical cover at night. They were able to respond to an emergency quickly as they live on site.
- Staff received and were up-to-date with mandatory training. The average rate was 91%. Training records showed staff received training in areas such as basic life support, crisis management, safeguarding, prevention and management of violence and aggression and suicide prevention. Training helped staff deliver care to patients safely.

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

Good

- All staff, including bank staff, completed a five day mandatory training on appointment. All staff we spoke to had found the induction beneficial and relevant to their roles. Agency staff completed an induction checklist. This covered the day to day running of the ward and expectations of staff. The checklist links the areas to the appropriate hospital policy which staff are instructed to familiarise themselves with. Some staff had received the induction whilst working at a different location. They told us that they were made familiar with the ward and routine with the same checklist. Health care assistants are encouraged to follow the care certificate standards as part of their on-going development. The ward manager and clinical services manager had been trained to deliver the Care Certificate standards.

Assessing and managing risk to patients and staff

- In the six month period before the inspection, Newington Court recorded 23 episodes of restraint. There were no recorded prone restraints. Prone position restraint is when a patient is held in a face down position on a surface and is physically prevented from moving out of this position. Department of Health guidance states that if such a restraint is unintentionally used staff should either release their holds or reposition into a safer alternative as soon as possible.
- Staff completed risk assessments of new patients on admission to the wards. Fifteen care records were viewed and all were detailed and up-to-date. The risk assessment tool was recognised to be suitable for acute mental health settings and included a personalised risk management plan. Staff told us that this plan helped to put appropriate measures in place to reduce risk, for example, frequency of patient observations.
- Newington Court patients did not have a key for their own room. Patients asked staff if they required their room to be locked or unlocked. Patients were not allowed to have cigarette lighters or plastic bags in their possession. Staff told us this was to reduce the risk of harm to patients and the environment. Individual risk assessments are not used to make a decision as to whether they can have these items.
- Informal patients are not able to leave at will. Staff told us that patients are made aware of this during admission. This information was displayed inside the ward entrance. We saw one care record where an informal patient was given leave in their care review
- Staff on ward 1 told us that they have eight 'safe rooms' (four downstairs and four upstairs) which are given to new patients for the first 72hrs after admission. The rooms are also used for patients with high risk of self-harm. Staff told us this helps them to ensure these patients are safe.
- Staff were unsure of the search procedure. Staff told us that patients would be searched when returning from leave or if they were concerned that a patient may be concealing an item of concern. Both wards had metal detectors which they used if they were concerned a patient was carrying a weapon.
- Staff that we spoke to showed good understanding of de-escalation techniques and how they are used to reduce anxieties and possible aggression. Staff had completed prevention and management of violence and aggression, crisis management and suicide/ self-harm prevention training and were confident in their ability to support their patients without needing to restrain them.
- We did not see evidence that the wards had used rapid tranquilisation to manage patient risks. Staff were aware that The National Institute of Health and Care Excellence guidance stated that the vital signs of patients should be monitored following rapid tranquilisation until they are fully alert. This was included in the policy around preventing and managing disturbed and violent behaviour.
- All staff had received safeguarding trained. Staff knew how to recognise a safeguarding concern and gave appropriate examples. Staff were able to name the safeguarding lead and knew where to find the safeguarding policy if they needed advice. The policy included a flowchart of how to raise a safeguard concern and assisted staff in taking the correct action.
- The hospital safeguarding lead told us that they oversee the safeguarding concerns and make safeguarding alerts to the East Sussex safeguarding team when

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

Good

required. We were shown examples of how safeguarding issues were discussed in supervision and handovers. The safeguarding lead also checked that concerns were updated in risk and care plans.

- Medicines management was being practiced well on both wards. We reviewed all the records of medicine administration and they were accurate. Medicines were stored securely. The fridge where medicine was kept had a temperature recorded daily to ensure it was fit for purpose. A local pharmacist visited weekly. The pharmacist audited the medicine records to ensure they were completed correctly and monitored the expiry dates of medicine to ensure they were fit for use.
- Children were not allowed on the wards. Patients who wanted visits from children were able to use a separate visiting room away from the ward and patient areas.

Track record on safety

- Newington Court had eight serious incidents requiring investigation between 18 November 2014 and 11 November 2015. A patient required medical attention after climbing on a roof and falling off. The hospital responded to this by making alterations to make the building anti-climb. All other serious incidents requiring investigation involved person on person physical assault. The hospital had been judged to take appropriate action to prevent further recurrences.
- The hospital were unable to give us individual safeguarding information for Newington Court. However, collectively, the hospital received nine safeguarding concerns between 17 February 2014 – 23 July 2015. The hospital had taken appropriate action in all concerns and none had required involvement from the local Social Services.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise incidents and record them on the electronic compliance system. Some staff were not registered on this system and used a paper format which the ward manager or senior staff nurse transferred onto the electronic system. The quality lead checked the description and action plan and returns them for amendments if necessary. The clinical service manager then checked them again before producing a weekly report which was sent to all managers.
- Staff not registered on the electronic system and the number of people involved meant outcomes of incidents could delay the process. However, debrief to patients was immediate.
- We saw a wide range of incidents being recorded. The weekly report included sections on patient debriefing, outcomes and lessons learnt. We tracked a random incident and found that all plans had been followed and the patients care records had been updated in line with the outcomes and lessons learnt.
- The hospital holds a monthly learning and outcome group which is open to all staff to meet and discuss incidents. Staff told us that they found this useful and supportive and attended when they had been involved in an incident. We looked at the minutes of the patient community meetings from the last three months and saw incidents were discussed. There was an open culture around reporting and discussing incidents to improve patient experience.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed 15 care records at Newington Court. The wards admit and discharge patients regularly and there was movement during our inspection.
- Patients' needs were assessed on admission and care was delivered in line with their individual care plans. Care plans showed a comprehensive focus on risk and medicines management. Patient's psychological and therapeutic needs were not regularly discussed in care plans. This meant that needs in these areas could be overlooked. We did observe a plan for a patient with challenging behaviour based around Positive Behaviour Support . This approach of teaching a more effective and acceptable behaviour than the challenging one, was included in the plan.
- The ward manager told us that some patients do not stay on the ward long enough to be assessed by other

members of the multidisciplinary team . The psychology assistant confirmed this and told us that if psychological assessment and recommendations are made, they will be included in patients discharge summaries. Patient's normal care teams can then act on these recommendations.

- We reviewed electronic progress notes written by occupational therapists. The notes showed a variety of care that were not included in care plans. All care plans we viewed had been developed into a recovery focussed plan.
- From the 15 records viewed, 13 patients had signed their plans and nine patients had a copy of their plans. Two patients had not seen or signed their plan. All fifteen care records reviewed included care plans that were up to date. Staff on ward 2 were better at including patient's views in their care plans.
- All patients received a physical health assessment on admission by a qualified doctor. We saw some identified physical health needs were included in patients care plans. One patient, who had diabetes, had a care plan in place to help them manage their condition. However one patient, who had arthritis, did not have a plan for their specific needs. All care records reviewed showed that physical observations were taken daily unless there was an identified need for more regular monitoring.
- Patients care records were stored within the electronic records system. Staff accessed the system with an identification card and individual password. This ensured confidential information was maintained securely. Staff we spoke with found the system easy to use and could find information quickly. Bank and agency staff told us they were all able gain access to the electronic records system.

Best practice in treatment and care

- Both wards were following The National Institute for Health and Care Excellence guidelines in relation to safe and effective use of medicines to achieve best possible outcomes for patients. Staff were aware of maximum doses for antipsychotic medicines as indicated in the British National Formulary and knew that all current patients were on suitable doses.
- Newington Court ran patient groups based on psychological therapies recommended by The National Institute for Health and Care Excellence . The assistant psychologist told us that they used cognitive behavioural therapy techniques within the groups. Patients were able to learn strategies to help reduce their symptom and techniques to help them relax. The assistant psychologist explained that it was difficult to plan long-term psychology for patients as they didn't stay long enough. The psychologist felt that Newington Court placed high importance on the psychological needs of patients and told us that recently a 'Head of therapeutic services' had been added to the team.
- We observed an occupational therapist assessing the needs of a new patient. They used the model of human occupation screening tool to determine their ability in cooking, shopping, personal care, budgeting and travelling. Occupational Therapists wrote detailed notes in the patient's notes. However, they were not often included in care and recovery plans. Patients and their care teams were less likely to benefit from these occupational assessments after they were discharged.
- The wards had a junior doctor and associate specialist, who were part of the multi-disciplinary team, who provide all physical health assessments, referrals to A&E, secondary and or specialist acute services as required. The wards had access to dieticians, chiropodists and other similar services when needed.
- Patients were assessed using the health of the nation outcome scales on admission to the ward. Clinicians were able see patients improvement or deterioration in 12 health and social areas over time.
- Staff used a risk assessment tool that was recognised to be suitable for acute mental health settings and included a personalised risk management plan.
- Psychology staff used an individualised psychological assessment including recognised tools to rate patients levels of depression (patient health questionnaire – 9) and anxiety (generalised anxiety disorder - 7). These tools had been repeated with patients to gauge progress whilst on the ward. Occupational therapy staff used information from the model of human occupation screening tool to decide on their therapeutic approach with patients.

Skilled staff to deliver care

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

Good

- Staff working on the wards came from a range of professional backgrounds including nursing, medicine, occupational therapy and psychology. Staff were supported by an external pharmacist who visited the wards weekly. A social worker worked in another area of the hospital. They were able to provide staff with advice on social issues of patients. Staff we spoke with were suitably qualified and had a good understanding of their roles and responsibilities. For example, an occupational therapist was seen displaying a range of therapeutic skills to obtain information for a screening tool from a particularly unwell patient.
- All staff, including bank staff, complete a five day mandatory training on appointment. All staff we spoke to had found the induction beneficial and relevant to their roles. Agency staff complete an induction checklist. The checklist covered the day to day running of the ward and expectations of staff. The checklist linked the areas to the appropriate hospital policy. Some staff we spoke to had received the induction whilst working at a different location. They told us that they were made familiar with wards setting and routine with this same checklist.
- Staff told us that they received regular clinical supervision and found it helpful and supportive. We looked at a random sample of five supervision records and all had received supervision in the last month. The records were comprehensive and addressed training requirements and requests, patient care, well-being, and other issues. All regular staff had received an appraisal in the last 12 months.
- Staff felt they had the necessary training to do their jobs. Staff had access to online introductory courses to improve their knowledge in areas such as autistic spectrum disorder. The ward manager told us that two qualified staff were starting their mentorship training this year. This will enable them to offer more student nurses a better learning experience when they have work placements on the ward. Two healthcare assistants were currently doing their national vocational qualification, which is a care certificate standard. The hospital also funded two healthcare assistants to undertake nurse training each year.
- The ward manager told us that poor staff performance was addressed poor with a personal improvement plan. This was specific to the hospital. The personal improvement plan allowed them to jointly identify areas that need attention and agree on a plan to support the staff members improvement in these areas. It included the opportunity for monitoring and review.
- During the inspection we saw many examples of good patient and staff interactions. However, staff did not always record these interactions effectively. This meant that opportunities for increased patient recovery and continuation of care after discharge could be missed.

Multi-disciplinary and inter-agency team work

- We observed a multidisciplinary meetings. They were held every weekday morning. A member of each professional discipline was present and all took part in reviewing the care of patients who had been admitted or planned for discharge. Time was given for updates on any risk or safeguarding issues and staffing levels were reviewed.
- Nursing staff had a handover each morning and evening on both wards. We saw that individual patient care was discussed and staff duties and patient allocations were clearly indicated on a handover sheet. Staff told us they knew their allocated patients and tasks for the day. The hospital director had introduced an objective to use positive statements about patients during every handover. We checked past handover sheets and found this wasn't being met.
- There was positive interagency working with the GP to support patients physical health needs. However, one patient told us he had been given a different dosage of a physical medicine as staff did not check this with his GP who was out of area. The ward manager told us that they had good relationships with care teams from the local area but not always from care teams from further afield.
- We observed an example of continuity of care during a discharge review of another patient from out of area. The patient's mother and nurse from the local crisis team were present via teleconference call. They were given a detailed account of the patients episode of care and were given the opportunity to ask questions which were answered. The patient was present throughout although did not express their views.

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

Good

- Staff told us the ward had introduced a form which patients could complete before they saw the psychiatrist. Patients had the opportunity to prepare for the meeting and be involved in their care.
- The ward manager told us they had positive links with the safeguarding team and local police who give advice when needed

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

- Staff across the hospital had a 92% completion rate in Mental Health Act training. Staff we spoke with had a good understanding of The Act, it's Code of Practice and guiding principles.
- Of the 15 patient care records we viewed across both wards, eight were detained under The Mental Health Act. All had correctly completed consent to treatment forms.
- The wards had a system in place to ensure that patients had their rights explained to them on admission and regularly after. We saw records that showed a patient had their rights repeated the day after admission as they had been unwell and unsettled.
- Staff had good support from the Mental Health Act administrator. This individual had systems in place to ensure staff filled out forms correctly and in a timely manner. They attended monthly governance meetings were they could feedback any issues to senior management.
- We were unable to locate the approved mental health professional report for one of the eight records we viewed. Other than this we found paperwork to be completed correctly and stored appropriately.
- The hospital completed an annual Mental Health Act audit which was submitted to the central organisation. The hospital manager also undertook quarterly reviews.
- We saw information for an independent mental health advocate displayed in both wards. Some staff were unclear how their role differed from the general advocate who visited weekly. This could lead to detained patients not being made aware of the specific service they offered.

Good practice in applying the Mental Capacity Act

- Staff across the hospital had an 89% completion rate for Mental Capacity Act training. Staff had a reasonable knowledge of the principles around capacity. We were told that the ward doctors took a lead on assessing capacity.
- We saw care records that showed that patients' capacity had been assessed on admission and in ward rounds. We did not view any care records of patients with impaired capacity but staff were able to locate the policy that gave them guidance around this area. Staff were also confidence to discuss capacity issues with the ward doctors or the Mental Health Act administrator.
- The service had not made any Deprivation of Liberty Safeguards within the previous year.

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

Good

Kindness, dignity, respect and support

- We observed positive and caring interactions between staff and patients, with privacy being maintained. These interactions were minimal on ward 2. All patients we spoke with told us that staff were respectful of their privacy and would knock on their door before entering.
- Patients on both wards told us they felt supported by staff. One patient on ward 2 felt that staff only interacted with him when asked, due to this he had felt quite isolated on the ward.
- A patient on ward 2 told us that they had not been able to get extra clothes after being admitted in an emergency. This meant they used towels to stay covered whilst their clothes were being washed. The issue about the lack of mens clothing on ward 2 had been discussed at the community meeting three weeks prior to our inspection. As a result of this meeting a plan had been made to address this. Staff were unsure why the plan had not been implemented.

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

Good

- Staff told us that it could be difficult becoming familiar with the individual needs of patients as they often have short admissions. We observed minutes from community meetings where patients had reported their care plans did not reflect their individual needs.
- The service had a policy of discussing patients in a positive way during handovers. We observed some recent handover sheets from both wards and found that this was happening, but not consistently.

The involvement of people in the care they receive

- Patients told us that they received a full orientation to the ward on admission. They told us that the admission process was carried out with minimal waiting. A patient guide was available on request. It was also displayed in the hospital entrance.
- We found a varied level of patient participation in their own care. The service used the recovery star, a self-rating on people's abilities in ten life areas. This supported patients and staff to create recovery focussed care plans. We saw this process working well in many cases. For example, a patient had a care plan that used positive behaviour support techniques. The patients challenging behaviour had been identified and agreed with staff how this could be managed in the least restrictive way. Other patients told us that they were unsure of their care plan. We viewed 15 care records and found that all care plans were present and up to date. Five care plans had full evidence, nine had some evidence and one had no evidence of patient involvement. We found that the care plans were focussed on clinical treatments and risk issues, with patients wider needs often being overlooked. Thirteen records showed that the care plan had been given to the patient.
- Patients were encouraged to participate in the discharge meeting and occupational therapy assessment we observed. The service gave patients a pre-ward round form so they could prepare before seeing the multidisciplinary team. Patients we spoke with found this useful.
- Advocates visited the wards weekly and their contact details were displayed on the ward. We found that staff had limited understanding of the difference between a general advocate and an independent mental health advocate, who has specialist training in supporting people detained under the Mental Health Act. This could lead to patients not getting the support they need.
- We observed families and external care teams being contacted via teleconference to get their views on patient care. As the wards admitted people from different areas of the country, the wards were flexible towards visiting hours. Patients we spoke with told us that their visitors were made welcome and there was appropriate areas available for private conversations to take place.
- Patients had community meetings every two weeks. The meetings were well attended and minutes from meetings showed that patients were confident to give feedback about the service. Issues raised were allocated to staff with action plans and expected timeframes for them to be addressed. We saw that small issues were resolved quickly, however, some maintenance issues had to be raised again. We spoke with two patients who were being discharged that day and they had both been given a questionnaire to give feedback about the service.
- The hospital director told us that they included patients on staff interview panels. Patients we spoke with were unable to confirm this due to not being on the wards long enough.

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

Good

Access and discharge

- The service had an average bed occupancy of 79% between the period 1 May 2015 to 31 October 2015. Having levels below 85% ensure admissions run smoothly and staff are able to deliver care more efficiently. In the same period there had been no delayed discharges. During our inspection there were six admissions and six discharges. The service told us that the average length of stay is ten days.

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

Good

- Patients were admitted from the local area when beds were unavailable in the local NHS trust. They were generally recalled to NHS beds when they became available. Patients were also admitted from other areas around the country. Patients often required admission during the night, the service was able to respond to this as they had two junior doctors living on-site.
- The service had a clear admission policy and checklist. Admission criteria excluded patients with a history of sexual offences due to the hospital site providing inpatient care for children. The ward manager was supported by senior managers and was able to refuse an admission if it would unsettle the environment. We saw care records of an admission from the previous 24 hours that showed that the admission checklist had been followed.
- The service had a target time of responding to the referrer with a decision within 30 minutes. They have good systems in place, including a member of staff allocated to referrals, to keep to this target day and night.
- All patients were discharged back to the referrer, which was the the crisis home treatment team. In the discharge meeting we observed the patient and staff from the crisis team were given appropriate information for continuity of care following the discharge.
- The ward manager told us that patients who required more intensive care were transferred to a local psychiatric intensive care unit. The unit was run by the same hospital group. We saw progress notes to confirm the service had efficiently managed this situation recently.

The facilities promote recovery, comfort, dignity and confidentiality

- Both wards had a number of rooms for use, including a quiet lounge, dining room and a clinic room. Patients had access to a multi-faith room, occupational therapy rooms and a gym. Patients had access to games and books. Minutes from the community meeting showed patients on ward 2 felt some activities, such as art equipment, was not as readily available as on ward 1.
- Patients had their own bedrooms with en-suite facilities. Televisions were provided if risk of self-harm and aggression was low. Patients were able to personalise their bedrooms and this was evident where patients had had longer admissions. Patients we spoke with told us maintenance issues could take time to be addressed.
- During our inspection both wards were settled and provided a comfortable environment for patients.
- Patients were able to have their own mobile phones. There was also access to ward mobile phones that patients could use in private. During the inspection the phone on ward 2 was not working.
- Patients on ward 1 had access to a garden area, although this was not available during our inspection due to maintenance. Patients on ward 2 only had access to the garden area if escorted by staff. We observed this being facilitated regularly during our inspection but patients told us that on occasions they had to wait for staff availability. An outside smoking area was being made for ward 1but this would still require staff to unlock a door for a patient to gain access.
- Patients told us that the food was of good quality and that snacks were available, including fresh fruit and hot and cold drinks, 24 hours a day.
- Both wards had secure places on the ward for their belongings. However, patients on ward 2 did not have lockable spaces in their own bedrooms. The ward manager told us that plans for new furniture would address this issue.
- The service offered a wide range of therapeutic activities to meet the psychological, social, creative and physical needs of patients. We spoke with three new occupational therapy staff who had plans to adapt activities to be more accommodating to men. This had been in response to feedback from recent community meetings. The majority of the groups were open to patients from both wards and took place on ward 1, in the gym or in the community. The service did not offer structured activities during the weekend, although movie nights were arranged by staff.

Meeting the needs of all people who use the service

- Both wards were accessible by wheelchair users. The ward manager told us that they would not accept referrals for patients with major physical or learning disabilities as the service was not tailored to meets these needs.

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

Good

- The ward manager told us they would accept referrals for patients whose first language was not English, however would expect patients to be able to communicate in English. The service received a significant amount of referrals daily so chose to accept patients whose needs they were able to meet. Interpreters were available to the service.
- Staff within the hospital site had 96% completion rate in the Equality Act 2010 training.
- The service clearly displayed information on local services, treatment and how to complain. Information on patients' rights was available in a format that was easy to understand.
- Patients told us that the food was of a good quality. The hospital had a catering department and provided a good choice of food that met the dietary requirements of religious and ethnic groups.
- Patients were able to access the local community to attend churches and groups for spiritual support. Information on local events was displayed on both wards.

Listening to and learning from concerns and complaints

- In the 12 months prior to our inspection the service had received nine complaints. Three complaints had been upheld. No complaints were upheld by the ombudsman. Complaints across the hospital site were about standards of care, missing property and discharge issues.
- Patients we spoke with told us they knew how to complain and would feel confident doing so. Minutes from community meetings showed that patients were comfortable raising concerns to staff.
- The hospital had a monthly learning and outcome group where incidents and complaints were discussed. Minutes from this group showed that patients had received feedback from complaints and lessons had been learnt.

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

Good

Vision and values

- Most staff we spoke with were aware of the hospitals visions and values. These were reflected in six quality improvement objectives which covered; improving therapy services; learning from incidents; staff training and personal development; and communication across the hospital site. Staff told us that these objectives were discussed at team meetings.
- Staff had good knowledge of the roles of senior managers and told us they were often present on the wards. The senior managers carried out monthly quality walk rounds where they observed the environment and staff interaction with patients. We saw logbooks which showed that issues raised were addressed. An example of this was making sure that staff wore name badges.

Good governance

- The service received suitable governance from the hospital's senior management team. The hospital held regular governance meetings and produced reports on key performance indicators. There were dedicated meetings for pharmacy and a committee dedicated to the National Institute for Health and Care Excellence guidelines.
- The ward manager had authority to adjust staffing levels and had input in the acceptance of referrals based on ward dynamics. We spoke with administration staff who told us they were supported by management and their workload was manageable.
- Staff were able to feed into weekly hospital risk meetings. Information from this was used to update the risk register.

Leadership, morale and staff engagement

- There was evidence of clear leadership from the hospital director through to senior management and ward managers. Staff knew management roles and felt they were approachable and supportive.
- We did not receive individual sickness rates for the service, however, the overall sickness rate for the hospital was 6% between 1 May 2015 and 1 November

2015. In the 12 months before our inspection the hospital experienced 47% of permanent staff leaving. The hospital director told us that staff retention was a priority and a number of initiatives, such as recruitment events and staff benefits, had been introduced.

- Staff morale was high. They enjoyed working for the service and felt supported by management and colleagues. We heard no incidents of bullying or harassment.
- Staff told us that they felt confident to whistleblow. They all said they would do this internally. They were not aware where they could raise concerns directly to the care quality commission to help maintain their anonymity.
- Staff were satisfied with the level of training they received and were able to attend further training to further their career. Two current members of staff were being funded to complete their mentorship qualification. The hospital funded two health care assistants to undertake their nurse training annually.
- Staff were able to input into service development. One member of staff told us they had introduced a tool to support patients prepare for meetings with their care team.

Commitment to quality improvement and innovation

- The service contributed to a number of audits carried out annually by the Priory healthcare group. These included reducing restrictive practice and evaluating clinical supervision.
- The wards were conducting their own audits to rate the value of therapeutic activity and monitor the amount and quality of primary nurses' one to one sessions with patients.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Requires improvement

Safe and clean environment

- There were three long stay and rehabilitation wards at Priory Ticehurst. The Highlands, Lowlands and the Lodge.
- The ability of staff to observe all parts of the wards was restricted. There were convex mirrors in some corners of the Highlands, however, one was positioned incorrectly. It was pointing at the wall rather than the corridor. There were blind spots on all three wards. Staff told us that the layout of The Lodge enabled staff to observe and manage the environment better than on the Highlands. There were a number of narrow corridors on the Highlands with unsighted 90 degree corners. The environment on The Lodge allowed for better observations. Staff told us the layout allowed for better patient observations and intervention in emerging incidents. Lowlands was a four bed room bungalow. There were blind corners, but the domestic style environment was manageable for staff.
- Ligature point audits had been carried out by a Senior Health Care Assistant (HCA) from each of the 3 wards (each acting as their ward's health and safety representative). A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. HCAs were trained to provide this role through training with the previous health and safety representative for the ward. This consisted of a discussion around the procedure. There was an extensive list of ligature points listed for each room. However, there was no context given for each rating score. A traffic light system was used for grading the level of risk but it was unclear how each rating had been reached. There were no details of a management plan in place based on the assessed level of risk. There was an "existing controls" measure in the assessment, "intermittent observation was cited for every ligature risk on Highlands. The existing controls measure was blank for all risks on The Lodge. We were told by staff on The Lodge they were not clear on what should be put on this section of the assessment. The ligature audit for Lowlands were completed more thoroughly. The range of existing controls were cited in further detail and directed staff to consider individual care plans and to undertake visual checks. The ligature audits on Lowlands were more detailed, however, no context was provided as to the level of risk the ligature posed.
- Ligature plans could fail to prevent harm to patients. For example, one patient on highlands had an identified suicide risk which included the use of ligatures. Additionally on the Lodge a patient had been found in their bedroom in March 2015 with a ligature around their neck.
- Of the three wards, only Highlands provided mixed gender accommodation. We undertook a detailed ward tour of Highlands and were told that males were accommodated on the ground floor and females on the first floor. There were four rooms on the ground floor and seven on the first floor. There was one vacant room on the ground floor. We reviewed the physical health monitoring files and it was apparent there were five

males and five females on the ward. We spoke with staff who confirmed there were five patients of each gender on the ward. We were told there were two males on the first floor. We explored further how mixed gender accommodation was being managed on Highlands ward. We were told that of the two males on the female floor one had en-suite facilities in their bedroom and the other went down to the ground floor to use the toilet and shower room. We could find no measures in place to ensure this arrangement was being facilitated consistently. We escalated this during the inspection and the male patient who did not have en-suite facilities was moved to the vacant room on the ground floor. This was completed with the agreement of the patient.

- Highlands ward did not have a dedicated female only lounge. We were told by staff that the multi-faith/quiet room on the first floor could be used as a female only lounge on request. This arrangement was not appropriate as the room did not provide a TV, books or any other stimulating activities. We did not consider that Highlands met the Department of Health guidance on mixed sex accommodation.
- The clinic rooms on each of the wards were clean, tidy and well organised. Medications were stored appropriately in locked cabinets that were secured to the walls. All medication charts were duly completed and signed. However, the clinic rooms on each ward were small and did not have an examination couch and were limited on space. Staff told us that patients are seen for medication, health checks and electrocardiograms in their bedrooms. Highlands had their own defibrillator. However, The Lodge did not have their own defibrillator and had to access the machine located on Highlands ward. We were told the Highlands had their own machine due to the age group and health concerns of the patient group on the ward. We asked staff if an emergency situation were to happen on The Lodge, would they be able to access the defibrillator within the recommended time scale of three minutes. This timescale is stated by the Royal College of Psychiatry. Staff we asked about this were confident the timescale could be met. We tested this by undertaking a mock medical emergency. Only the management were aware this drill would be undertaken and specified a room on The Lodge where the emergency was. Initially there was confusion as the staff radios were not working correctly. Information about the medical emergency had to be telephoned across to the Highlands ward where a member of staff collected the defibrillator. Staff response to the emergency was good and several attended The Lodge to assist, however, there was confusion over which room the defibrillator was required was in. The time from the first response call to the presentation of the defibrillator in the correct room was 10 minutes and 14 seconds. This is well in excess of the recommended guidelines of three minutes.
- All three wards were clean, tidy and well lit. All communal areas were clean. Staff and patients told us that there had been a recent program of redecoration and new furnishings had been installed.
- Equipment on all three wards was well maintained, clean and stickers were visible and in date. We reviewed cleaning records and schedules. They were all up to date.
- Staff on all three wards adhered to infection control processes.
- Staff used radios to communicate with each other and between different wards. There were nurse call buttons on the wall in each room. These alerted staff if a patient required assistance.
- There were no seclusion facilities in any of the three wards. Staff told us seclusion was not used on the wards.

Safe staffing

- The Highlands and The Lodge had a qualified nurse on duty by day and by night. The Lowlands had two health care assistants (HCAs) who work day time shifts.
- The three wards had a dedicated staff grade doctor and responsible clinician (consultant psychiatrist). The hospital had a service level agreement with a local General Practitioner who provides a dedicated service for the long stay rehabilitation wards. There were two dedicated duty doctors that attend the hospital on rotation and are accommodated on site during their rotation.
- The three wards regularly used bank and agency staff. The hospital had contracts with local agencies that provide nursing staff on a block booking basis. This was to avoid using ad hoc agency staff that were unfamiliar with the patients or the wards.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The three wards had the following vacancies: one deputy manager (who had been recruited but was awaiting a start date), one charge nurse (who was to take the lead on physical health, this was a brand new Band 6 post that had been agreed), one band 5 nurse and fives HCAs.
- Staff told us the service on the Lowlands and the Lodge was not negatively impacted by the level of vacancies or the use of bank and agency staff. However, staff told us the lack of regular and stable nursing cover on the Highlands could negatively impact the running of the ward. For example agency nurses, even if block booked, were unable to access the hospitals computer system and could not access patient records, incident logs and other information stored electronically.
- Staff had received and were up to date with mandatory training. There was a 95% compliance rate. However, staff we spoke with had a poor level of understanding about the Mental Health Act and Mental Capacity Act and Deprivation of Liberty Safeguards.

Assessing and managing risk to patients and staff

- In the six month period from May 2015 to October 2015 there were 13 reported instances of restraint used on Highlands (involving four different patients). There had been five instances of restraint on the Lodge (involving two different patients). There were no reported instances of restraint on Lowlands ward. There had been no use of prone restraint or rapid tranquilisation on any of the three wards.
- The service did not have appropriate systems in place to monitor specific risks to their patient group. The wards accommodated several patients over the age of 65. However, we saw only two completed Malnutrition Universal Screening Tool (MUST) forms, which were out of date. There was a lack of evidence that the wards effectively monitored and managed the risks associated with changes in body mass.
- Risk assessments were completed on admission and then monthly. The assessments were very detailed and in depth. However, information on the risk screening on the care plans was inconsistent with the information concerning risk written on the client board and alerts. One patient had been identified as having very high risk behaviours on their risk screening but had been put as a medium risk on the board and no information regarding their aggressive behaviour had been put on their alerts.
- Staff we spoke with were able to list different types of abuse and cite appropriate actions they would take if they witnessed abuse taking place. Staff were familiar with how to raise a safeguarding alert. However, staff told us that they were not given feedback on the outcome of safeguarding investigations.
- Staff kept stock of routine medications in the clinic room on all three wards. The hospital had an agreement with an external pharmacy who delivered medications as and when required. A pharmacist visited the wards weekly to audit medicine cards and to manage medicines. We found evidence that controlled drugs were managed appropriately.
- Children under the age of 18 could were not allowed to visit patients on the wards. However, there was a child friendly visiting room available within the hospital for visitors who were under 18 years of age.

Track record on safety

- Between November 2014 and November 2015, there were a total of 17 Serious Incidents Requiring Investigation (SIRIs) on Highlands ward, seven on the Lodge and none on Lowlands.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were able to give examples of incidents that would need to be reported. They were aware of the need to inform members of ward and hospital management when an incident report had been completed. However, staff told us that they are not given feedback on the outcome of investigations into incidents.
- We saw evidence of discussion about recent incidents in the minutes of regular Clinical Governance Committee meetings.
- Incident reports were inconsistent across the three wards. Some staff told us incidents were reported electronically via e-compliance and some staff completed incident forms on paper which were stored in a file kept in the office.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Agency staff were not given log in details and were unable to access computer systems. They had no access to patient files and information and could not report incidents. Staff told us that they wrote information onto pieces of paper that they then gave to staff at the end of their shift in order for the information to be recorded electronically. This information could be relating to physical health checks, patients behaviours or incidents.
- The incident reports we looked at had very little information relating to the incident or what outcomes or investigations had been carried out. There was also no information lessons had been learnt. Some incidents had been recorded under the wrong ward name.
- There was a behaviour monitoring form completed for each patient. This contained information about any violent or aggressive behaviour and the outcomes. We cross referenced these with incident reports and could not find incident reports about the entries completed.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Comprehensive assessment of individual needs and risks were completed on admission. These included physical examination and identification of physical health problems. However, records we reviewed indicated that on going monitoring of physical health problems was sporadic after the initial assessment. There was inconsistency between electronic and paper records and the recording of physical health. Some information was recorded in care plans and some in separate paper files in the ward offices. Staff told us this could lead to confusion in accessing up-to-date information on individual patients.
- Care plans we looked at were holistic, recovery-oriented and up to date.
- There was a significant level of inconsistency between electronic and paper records. Staff we spoke with told us that this can lead to confusion in them being unable to access the most up-to-date information on patients.

Best practice in treatment and care

- Psychology input was available to patients. The multi-disciplinary team included a clinical psychologist and an assistant to psychologist. More intensive interventions, such as Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR), were available to individual patients as appropriate.
- Patients had access to on site psychiatric and physical health input from doctors based at the hospital. They also had access to community-based health professionals, such as dentists and podiatrists, as required.
- A full assessment of physical health was conducted upon admission. However, regular monitoring of physical health was inconsistent, particularly in relation to general risks associated with the age group of many of the patient cohort (e.g. nutrition and hydration). Recording on individual monitoring charts was very sporadic. There were gaps of several weeks between readings, even for patients who were deemed to require daily observations.
- The wards utilise the Commissioning for Quality and Innovation (CQUIN) framework for setting goals and monitoring the performance of service delivery.
- The ward manager takes part in a program of monthly audits on each ward. The focus is on a different aspect of service delivery or ward environment each month.
- There was a lack of a meaningful rehabilitation and recovery program on Highlands and the Lodge. Activities centred around entertainment and simply occupying patients' time (for example art and music sessions), rather than activities aimed at preserving and enhancing daily living skills.

Skilled staff to deliver care

- The wards had access to a full range of mental health disciplines, including psychiatrists, psychologists, nurses and occupational therapists.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff told us they did not feel that they had been given specialised training to effectively care for the patient group. They reported gaps in their knowledge in subjects including dementia and Korsakoff's Syndrome. Staff also told us that they were unhappy with the heavy reliance upon the eLearning mode of training provided.
- All 21 non-medical staff had received an appraisal.
- Supervision levels were inconsistent. Some staff told us they received supervision monthly and felt supported. However, other staff had not received supervision for over three months due to staff and management changes.
- Locum nurses were not granted access to computer recording systems and were unable to record their own daily findings or look at historical records in relation to patient care plans, monitoring data or risk assessments.
- The new ward manager had been in post for four weeks at the hospital and still did not have access to the computer system. The manager was unable to access patient information, such as care plans and risk assessments, or incident logs.

Multi-disciplinary and inter-agency team work

- Brief multi-disciplinary team (MDT) meetings took place every weekday morning. The ward manager attended and provided updates on any concerns, present risks, staffing levels and recent incidents to the hospital senior management team. Following the daily MDT meeting, the ward manager held a daily meeting with the staff grade doctor for the three wards, along with a staff representative from each of the three wards. In this meeting information and issues discussed at the MDT meeting were disseminated to formulate a plan for that day.
- The ward manager attends at least one shift handover on every ward each week.
- There were no concerns relating to working relationships with external stakeholder organisations.

Adherence to the Mental Health Act and the MHA code of practice

- Staff we spoke with had a poor level of understanding of the MHA, the Code of Practice and the guiding principles. 92% of staff had received training in the Mental Health Act.
- Consent to treatment and capacity requirements were adhered to.
- We found evidence that patients have their rights under the MHA explained to them on admission and routinely thereafter.
- Detention paperwork was filled in correctly, was up-to-date and stored correctly.
- Specialist administrative support was provided by a dedicated MHA Administrator whose office was in the main hospital building.
- Patients have access to Independent Mental Health Advocacy service.

Good practice in applying the Mental Capacity Act

- Staff we spoke with had a poor level of understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. 89% of staff at the hospital had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- We found evidence that capacity to consent was assessed and recorded appropriately for people who might have impaired capacity. Decisions were recorded appropriately.
- Deprivation of Liberty Safeguards applications were made appropriately if required.
- Specialist Independent Mental Capacity Advocacy services were available to patients.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

- We observed numerous instances of staff interacting with patients in a caring, respectful and responsive manner.
- We saw evidence that staff had a high level of understanding of the individual patients. Staff also had a thorough understanding of practical and emotional needs of their patients.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff we spoke with were very passionate about the patient group and the care they received.
- Patients we spoke with told us that they were happy with the way staff treated them.

The involvement of people in the care they receive

- The admission process to all three wards involved substantial planning. The manager and occupational therapist visited the patient prior to admission. The patient would also visit the hospital once or twice prior to admission to help orientate themselves to the ward.
- There was a lack of evidence that patients had been involved in planning their care. The majority of care plans did not show evidence of being personalised in line with the patient's views.
- Patients had access to advocacy services.
- Patients were able to provide feedback on the service they received through community meetings. Patients we spoke with told us they would have preferred a daily community meeting and not a weekly one. Patients we spoke to expressed a desire to have a daily community meeting so they could discuss each day's activities and menus could be discussed.
- A program of redecoration and refurnishing had recently taken place. Patients told us that they had not been asked their opinion about the colour schemes used, the choice of furniture or art work on the walls. Some patients told us that they did not like the colours that had been used or the pictures that had been mounted on the walls.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- The average bed occupancy on each ward between May to October 2015 was 93% on Highlands, 88% on the Lodge and 63% on Lowlands. Bed occupancy levels are the rate of available bed capacity. It indicates the percentage of beds occupied by patients. The bed occupancy levels for the wards were as follows.
- There had been some instances of delayed discharge. We were told the primary reason for delays in discharge was a shortage of suitable placements being available.
- Patients are only moved between the three wards if there is a change in behaviour or interpersonal difficulties between patients.
- Beds are kept open for patients when they go on leave

The facilities promote recovery, comfort and dignity and confidentiality

- Highlands and the Lodge both had a clinic room. However, they were both too small to accommodate an examination couch. Patient examinations and tests were routinely conducted in their bedroom. Highlands and the Lodge both had an activity room.
- There were no rooms allocated for patients to spend time with visitors on the wards. They either used the patient's own bedroom or the activity room on the ward.
- Patients on all three wards had access to outside garden areas. The rear gardens on Highlands and the Lodge were secured by a high perimeter fence. The garden for the Lowlands ward was open and only partially enclosed by a hedge and fence.
- All patients had access to a communal mobile phone that allowed them to make calls in their rooms in private.
- Activities on Highlands and The Lodge were organised and led by the Occupational Therapy team on weekdays. During weekends and evenings, ward staff were expected to lead on activities – there was limited evidence of activities happening during these times. Overall, the therapeutic and developmental quality of activity program was limited – the type of activities on offer (such as art and music) were of an entertainment type, rather than assisting patients to recover or rehabilitate (in line with the 'Recovery and Rehab' titles of the wards). We saw evidence that the activity program was severely limited on Highlands and The Lodge when the OT team were not on duty.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Activities on Lowlands were primarily led by the ward staff. We saw evidence that patients took a full and active role in cooking daily meals, gardening and a range of outings (such as swimming, shopping and bowling).
- Each patient on Lowlands had a small safe and lockable drawer in their bedroom. A significant proportion of rooms on the other two wards did not have such facilities.
- Patients on all three wards had access to drinks and snacks 24/7.
- Patients were able to personalise their bedrooms. However, not all patient bedrooms had been personalised. This was the choice of the individual patient.
- Patients did not complain about the quality of food. However, some patients we spoke to told us that they were not happy with the choices on offer. Meals were cooked centrally in the main hospital building and delivered to the three wards. Some patients told us that they preferred traditional English food and did not like the international dishes on offer. Patients said they were not consulted on the choice of menu and we observed patients choose not to eat the daily menu choice and make their own food

Meeting the needs of all people who use the service

- Lowlands had recently been fully adapted for people with restricted mobility. There were ramps to the front door and rear door leading into the garden. The bungalow had level access throughout. The doorways had been widened. The bath and shower facilities were also suitable for wheelchair users. However, the environment on Highlands was not appropriate for people with restricted mobility. There were narrow corridors that had uneven flooring and a number of tight corners. Access to some areas of the building would therefore be problematic for wheelchair users.
- Information leaflets were available in accessible formats, such as large print or in easy read or pictorial formats. Leaflets could be translated if required and there was information about interpreting services on the ward notice boards.
- Details of local churches and other forms of spiritual support were clearly displayed on ward notice boards.
- Staff identified dietary requirements of patients when admitted to the wards. Any dietary requirements were discussed with the hospital kitchen so arrangements could be made for cultural and religious food preferences. Arrangements were also made for patients who may have allergies or require gluten free options. Ticehurst had been awarded a food hygiene rating of five (very good) by Rother District Council in August 2015.

Listening to and learning from concerns and complaints

- Patients we spoke with told us that they felt able to raise concerns about the service. There were clear notices on all three wards about the complaints procedure.
- Staff we spoke with were able to tell us the basic process for handling a complaint. However, staff told us that they are not given feedback on the outcome of investigations into complaints.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Requires improvement

Visions and values

- Staff were aware of the visions and values of the Priory Group. Staff were able to tell us the values and told us they subscribed to them. The visions and values were Priory Group wide and included putting people first, being a family, acting with integrity, striving for excellence and being positive.
- Staff we spoke with told us that they knew the members of the hospital senior management team and that they visited the wards.

Good governance

- Compliance levels for mandatory training was high. However, staff knowledge and understanding of the Mental Health Act, the Code of Practice and the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) was poor.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Supervision for staff was inconsistent. Some staff reported they received monthly supervision sessions. However, other staff stated that they had gaps of more than three months between supervision sessions.
- Not all incidents had been reported appropriately.
- Staff we spoke with told us that they do not receive feedback on investigations into complaints, incidents and safeguarding concerns.

Leadership, morale and staff engagement

- Staff we spoke with were highly motivated and informed us that they felt valued and appreciated by the organisation. Staff felt trusted to do their jobs.
- Staff we spoke to told us that there was inconsistency between wards but felt positive that this would change with the introduction of new management.
- Staff were able to tell us about the whistle-blowing process. They told us that they were confident that the hospital would properly investigate concerns.

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Good

Safe and clean environment

- Garden court ward and upper court ward were both situated inside a purpose built hospital. Garden court was on the ground floor and upper court was on the first floor. Garden Court was a Tier 4 acute unit. Upper court was a tier 4 high dependency unit (HDU). Garden court was clean and well maintained by two dedicated house keepers. Garden court had 13 patient bedrooms, three male and ten female rooms. One of the male bedrooms provided en-suite facilities. Two of the female bedrooms provided en-suite facilities. There were two female bathrooms and a toilet for female patients. There were appropriate gender segregation arrangements in place. There was a male bathroom and toilet. The ward had a bright and spacious group room, dining room and quiet room. Furniture in all areas of the ward was new and in a good state of repair. Upper court was clean and well maintained. There were dining room and lounge areas. There were 13 female bedrooms. Bedrooms did not provide en-suite facilities and had an anti-ligature sink in each room. There were two toilets with shower facilities and two bathrooms with toilet and shower facilities. The ward had a quiet room and group rooms. All areas of the ward were bright and well maintained with age appropriate décor. Young people on both wards had access to outside space under staff supervision. The outside area was a secure garden. The garden had been astroturfed. Young people required supervised access to the garden area with a staff escort.
- There were blind spots throughout both ward areas. These were mitigated by CCTV and the use of zonal areas where staff were deployed to assist with observations.
- Several young people and their relatives told us the temperature throughout the hospital was very cold. This was confirmed during our detailed ward tour and we found the temperature throughout both ward environments to be cold.
- Young people did not have bedroom keys. They had to ask staff for access to their bedrooms.
- The hospital completed yearly ligature audits to identify ligature risks within the wards. During a detailed tour of the wards we reviewed the environment for ligature risks. Points had been identified on the audit and actions put in place for staff to manage the risks. However, we found that not all ligature points had been identified on the audit.
- Staff had access to ligature cutters. These were located at different points around the ward including the staff office and corridor.
- We found the wards to be compliant with Department of Health guidance on same sex accommodation. Each young person admitted to the hospital was provided with a bedroom. On Garden court there were separate toilet areas for males and females. Bedrooms were zoned appropriately.

- Clinic rooms were located close to the communal areas of both wards. The clinic room on Garden court was next to a small examination room. The temperature in both rooms was very cold. The clinic room was well equipped with an examination couch, height and weight machines, blood pressure, pulse and temperature monitoring equipment. All were in working order and monitoring sheets had been completed. There were stocks of prescribed medication. All medication was regularly checked and in date. Prescription charts were completed daily. We found three entries for administered medication had not been signed on the morning of the inspection. This was escalated and rectified immediately. The fridge was locked and temperature checked daily. The clinic room on Upper court was next to a small examination room. The temperatures in both rooms were very cold. The clinic room was well equipped with all necessary physical health monitoring equipment. However, we found the blood pressure machine was not working. We escalated this and new batteries were fitted in the machine immediately. Prescribed medication was regularly checked and in date. The fridge temperatures were recorded daily and sheets signed to confirm this had been completed. Clinic rooms on both wards were clean and well maintained.
- There were no seclusion rooms on either of the wards. Both wards had a 'soft room' which had a padded floor. Staff told us young people would be taken to this room to de-escalate challenging behaviours but were not secluded. We were told this room was used by young people as a quiet room. The room did not have a door and staff observed young people in them from the entrance if they were exhibiting challenging behaviour. We were concerned this room could be used for "de facto" seclusion, however we found no evidence of this.
- Ward environments on both Garden Court and Upper Court were bright, clean and well-maintained. There were dedicated housekeeping staff who were responsible for cleaning the wards. They held a cleaning schedule which was up to date. Young people we spoke with stated that the wards were clean and their bedrooms were cleaned regularly.
- Annual environmental risk assessments were undertaken on both wards. These identified risks and rated them.
- There were nurse call systems in patient bedrooms on both wards. Staff were also issued with personal safety alarms.

Safe staffing

- Staffing levels were set at two registered mental health nurses and five healthcare assistants in the day and night. Ward managers were supernumery to this number. In the event of increased observations staff were absorbed in the first instance. For example if a young person required increased observations and required a nurse with them at all times. Extra staff would be requested for further increases in observations.
- The two wards had a reliance on bank and agency staff due to staff retention and recruitment issues. The hospital had contracts with local agencies and provide nurses who are trained in line with expectations of the hospital. Where possible staff would be booked on block contracts. This meant that temporary staff knew the running of the wards and the risks of the patients. The hospital had a recruitment and retention plan. Relocation packages had been offered to staff. If the staff member was from abroad the hospital assisted with signing them up to local GPs, acquire national insurance numbers and help with accommodation. Language tests were completed for staff members from abroad.
- We found that in the period between 1st October 2015 and 16th January 2016 Upper court had needed to cover 452 shifts with bank and agency staff. There were no shifts that had not been filled with the appropriate number of staff. In the same period Garden court had covered 139 shifts with agency staff. There were no shifts not filled on Garden court.
- We found that the impact of staffing on young people on the wards was minimal. Young people told us they were supported by staff and were able to access 1:1 time with nurses on the ward. Young people had both a primary nurse for one to one sessions and also a primary health care assistant.
- We were told by staff that patient's leave was rarely cancelled due to staffing levels. There had been times when leave was cancelled due to incidents on the wards.

Good

Child and adolescent mental health wards

- There was 24 hour on call doctor cover. There was a flat within the hospital grounds where the doctor would stay and was easily accessible. The child and adolescent mental health consultants were also on call out of hours and had a rota system in place.
- There was a 97% compliance rate for mandatory training.

Assessing and managing risk to patients and staff

- Young people were assessed on admission to both wards by nursing staff and by one doctor. Two clinical admission assessments were undertaken. Staff used the Priory assessment tools for new admissions. The assessment considered risk issues, psychiatric history, social history and a physical examination. We saw that risk assessments were thorough and updated weekly.
- There were some blanket restrictions on both wards. Post admission young people were not allowed to wear long sleeves, bras or socks for a 72 hour period. We were told this was while the young person's risks were assessed. Young people were also not allowed to keep items of clothing in their bedrooms. They were instead kept locked in their own personal locker in a locker room.
- The wards both had locked doors. Young people were not able to leave at will. However, there was information for informal young people on the notice boards about their right to leave. There were 14 informal young people across the two wards.
- The wards had policies and procedures in place for the observation of young people. Young people were at a minimum had observations completed four times per hour. The level of observation may be increased depending on risk. The multi-disciplinary team would adjust the levels of observations if required. Young people were prevented from accessing their bedrooms during the day so they would access therapies or education.
- Staff on both wards searched young people upon their return to the wards after leave. This was to ensure that contraband items such as sharp objects used to self-harm were not brought onto the wards. Young people were not pat down searched and instead a wand device was used. There was a clear policy in place about the searching of young people.
- There had been 123 restraints on Upper Court and 13 on Garden Court in the six month period prior to the inspection. None of the restraints were in the prone position (prone is when a young person is restrained on the floor face down).
- There were no episodes of seclusion or long term segregation in the same period. Neither of the wards had a seclusion or segregation room.
- Staff received mandatory training in the management of violence and aggression. Staff told us this training covered verbal de-escalation training and also restraint techniques. Staff we spoke with felt the training was robust and prepared them for managing challenging behaviour. Staff we spoke with confirmed that prone restraint was not used on either of the wards. Some staff cited and were knowledgeable about guidance from the Department of Health that states it should be avoided.
- Staff were aware of safeguarding processes and had received formal training. The wards had a safeguarding lead who was a social worker. The safeguarding lead liaised with the local authority and external social workers about any issues on the wards. The wards kept a safeguarding log with past and present alerts. We reviewed the log and found that issues had been raised appropriately. We found that issues were raised appropriately. Staff were also trained in safeguarding as part of their mandatory training.
- Staff kept stock of routine medications on both wards in the clinic room. The hospital had an agreement with an external pharmacy who delivered medications as and when required. A pharmacist visited the wards weekly to audit medicine cards and to manage medicines. Controlled drugs were not kept on the ward and were held on another ward. We found evidence that controlled drugs were managed appropriately.
- Children under the age of 18 could were not allowed to visit young people on either of the wards. However, there was a child friendly visiting room available within the hospital for visitors who were under 18 years of age.

Track record on safety

- There had been six serious incidents in the 12 months prior to the inspection.

Reporting incidents and learning from when things go wrong

Good

Child and adolescent mental health wards

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- Staff we spoke to were knowledgeable about what incidents should be reported. Staff knew how to report incidents on their electronic record system. The hospital kept a log of incidents, by service line, and these were reviewed by the hospital manager on a daily basis. The incident analysis was good. There were reports that could be generated that provided analysis of incidents by time of day and on which of the wards it had occurred. This allowed the hospital to identify trends and put measures in place to address spikes in incidents. For example it was identified there was a spike in incidents when a number of staff were in a morning meeting.
- Following incidents there was a de-brief for both staff and young people. This allowed staff and young people to reflect on incidents and learn from them.
- Feedback was provided to staff through lessons learned. Staff at Ticehurst were also included about incidents that had happened in other Priory hospital sites.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- During admission to both wards young people were separately assessed by nursing staff and a doctor. Both the nurse and doctor completed a separate Priory assessment tool. The assessments considered circumstances of the admission, social background, family history, developmental and forensic history. The assessments also considered issues around dietary requirements and allergies. On admission young people were provided with an information pack about the wards, checked in young people's possessions and orientated young people to the ward.
- There was a checklist of expectations for doctors to complete during admission. This covered issues such as consent, capacity assessment and consent from the family. Young people were able to request a gender specific physical examination.
- We reviewed five care plans across the two wards. Care plans were created with the input of the young person and also based on information gathered on admission. Care plans were also reviewed based on 1:1 times with named nurses. We found care plans to be personalised, holistic and recovery orientated.
- Care plans were reviewed with young people at ward rounds. We found the care plans were patient focused and written with the young person choosing how they were to be cared for. Young people were invited to complete a sheet about their views and wishes prior to weekly ward rounds where care plans were reviewed and updated.
- Physical health assessments were completed on admission to the ward. Young people were able to request a gender specific physical examination. Young people underwent regular physical health observation that was shared with their GPs. There was a full time staff grade doctor who forms part of the multi-disciplinary team . The doctor liaised with the young people's GPs as required. Young people's physical health was monitored regularly and this was stored with the young person's medication charts.
- Staff stored care plans on their electronic computer system. There was also a paper based version of these records for ease of access. Young people were provided with a copy of their care plans. Young people showed us a copy of their care plan which was stored in their bedrooms.

Best practice in treatment and care

- We found that doctors had incorporated National Institute for Health and Care Excellence (NICE) guidance into their practice. There were quarterly learning workshops to discuss NICE guidelines. Doctors did presentations at the workshops about any changes or updates to NICE guidelines. Policies within the hospital had also been amended due to updates in the guidelines, for example rapid tranquilisation and self harm. Regular email updates were sent to staff about guidelines.
- There were psychologists available to both wards who offered young people psychological therapies. These included Cognitive Behavioural Therapy (CBT), mindfulness and coping skills. There was a dedicated family therapist available to both wards.

- There was an arrangement with a local GP who visited the wards weekly.
- Health of the Nation Outcome Scales Child and Adolescent Mental Health (HONOSCA) were used to measure outcomes for young people admitted to the wards. HONOSCA measures symptoms and social and physical functioning. Staff also used Children's Global assessment Scale (CGAS) to rate the general functioning of children. Both HONOSCA and CGAS were completed on admission and discharge.
- There were regular audits completed by clinical staff. These included audits of care plans, and risk assessments.
- The wards had developed a bespoke training package called the CAMHS rolling programme. This was monthly training where issues relating to young people were presented and discussed to aid staff learning. Learning from incidents was also discussed. Staff we spoke to said this had been a valuable resource in the absence of formal training relating to child and adolescent mental health. Staff spoke very highly of this initiative.

Skilled staff to deliver care

- There was a range of mental health disciplines working across the two wards. This included consultant psychiatrists, nursing staff, psychologists, occupational therapist and a family therapist. The multi-disciplinary team met daily to review patients and consisted of social workers, occupational therapists, doctors, nurses, psychologists and the head teacher of the school.
- Staff received mandatory training. Training was provided by the hospital in face to face sessions or through computer based e-learning. New staff were inducted to the hospital through a corporate induction and then to the wards. Mandatory training covered training subjects such as Safeguarding and the Mental Health Act. All staff were required to complete management of violence and aggression training.
- Staff on both wards received supervision every month and were up to date with their appraisals.
- Staff told us about the CAMHS rolling programme that had been developed within the hospital. This was a regular learning session that was specific to CAMHS. Staff told us this had been an invaluable learning resource.
- Staff were able to access specialist training. We were told about health care assistants who had trained to be nurses or were training to be nurses.

Multi-disciplinary and inter-agency team work

- The multi-disciplinary team met daily to review every young person on the wards. There were also mutli-disciplinary team meetings weekly. We observed a multi-disciplinary team meeting. It was well attended, detailed and holistic discussions took place. We observed a patient-centred and respectful approach. Risk and safeguarding concerns were discussed. All team members present were given the opportunity to contribute to the meetings and their views were listen to and valued by all in attendance.
- There were effective shift to shift handovers that contained a summary of the young people's presentation and risks on both wards.
- Staff worked closely with community teams to ensure that they were updated about young people. Community staff were invited to Care Programme Approach meetings. The school also liaised closely with the schools young people had previously attended. This allowed for individual specific work to be provided to young people.

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

- Staff received training in the Mental Health Act (MHA) through the hospital. Staff we spoke with were knowledgeable of the different sections of the MHA and how they may restrict young people on the ward.
- Consent to treatment was recorded on admission and young people had their consent reviewed regularly. Consent to treatment forms were kept with medicine cards and the MHA administrator sent reminders to staff if consent was due for review.
- Section 132 where a patient is read their rights under the MHA was completed regularly.
- There was a standardised form for approving Section 17 leave. Patients who are detained in hospital have the right to lawfully leave hospital if they have leave of absence approved by their responsible clinician under section 17 of the Act.

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Good

Child and adolescent mental health wards

- There was access to an Independent Mental Health Advocate (IMHA) who visited the hospital.

Good practice in applying the MCA

- The Mental Capacity Act (MCA) does not apply to young people aged 16 or under. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves.
- Staff we spoke with held knowledge of the Mental Capacity Act (MCA) and of the hospital policy. Staff had received MCA training. Capacity to consent was assessed on admission and there were weekly prompts for the multidisciplinary team to reassess capacity around decisions in the team meeting.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

- We observed a range of interactions between staff and young people on both wards. Staff interacted with young people in a caring and compassionate way. Staff responded appropriately to young people in a calm, polite and respectful manner. Staff were interested in the well-being of young people on the wards.
- Young people we spoke with stated nurses were visible on the wards. They said they were treated with respect and felt safe at the hospital. Young people told us staff listened and responded to their needs. Young people told us staff always knocked before entering their bedrooms and respected their dignity.
- All young people we spoke to told us staff were always around and willing to engage with them.
- Staff we spoke with on both wards were knowledgeable about each individual young person. They were aware of their needs and any associated risks.
- Young people told us that activities were cancelled very occasionally, usually in the event of an incident on the ward. We spoke to staff on the ward who stated sometimes activities could be cancelled due to staffing pressures.

The involvement of people in the care they receive

- Staff orientated young people to the ward on admission. Admissions to Upper court were emergency admissions as it was a high dependency unit. On admission young people were assessed by both nursing staff and the doctor. Individual assessments were completed. The rules of the wards and expectations were explained to young people as soon as practically possible following admission. The admission process gathered information about the young person and their preferences and history.
- We found care plans to be thorough and holistic. Young people were consulted in the creation of their care plans. Care plans were individualised. Ward rounds were led by the young person and they were encouraged and supported in completing written submissions to be given to the consultant psychiatrist. This allowed the young person to be given the opportunity to be heard and raise any issues about their care. Young people were offered a copy of their care plan. This had not been accepted by young people in all instances and was documented in their notes.
- There were advocacy services available to both wards. An advocate visited the ward each week. There were posters on the wards promoting the advocacy service and offering information on how to make contact with the service.
- We spoke with parents who were positive about the care their children received at the hospital. They felt they had been involved in the care of their children and received detailed information packs in the post. This included information on how to raise a complaint. Parents stated the staff were friendly, helpful and informative. Parents told us when they had requested information about the care and progress of their children this was quick and efficient. The wards offered family therapy and had a dedicated family therapist. Staff made a daily phone call to each family to give an update on their relative. In addition the consultant also had regular contact with families. The ward had also produced a booklet for

families, explaining how the ward worked and the reason for restrictions placed on the patients. One relative we talked to spoke highly of communication from Upper court and stated they had requested to be contacted at any time of day if their child was involved in an incident and not to wait until the next daily phone call for an update. Staff on the ward did this.

- Staff facilitated a community meeting for young people once per week. Young people chaired the meeting. Young people were able to discuss issues on the wards. Changes made as a result of the community meeting were reflected on the "you said, we did" board on the wards. There were also suggestion boxes available in the lounge areas of the wards. Young people told us staff were good at giving young people feedback as a result of suggestions from the meetings and the boxes.
- Young people were involved in decisions about the service. We were told young people had sat on interview panels for the recruitment of new staff. Young people also attended multi-disciplinary team meetings and clinical governance meetings and were able to input about the running of the wards.

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

Good

Access and discharge

- The wards did not admit into beds when young people were on overnight or weekend leave. This enabled young people to return to their room if they returned from leave early and after completion of their leave.
- Young people were occasionally moved between wards. This was due to their acuity either increasing or decreasing and moving between the high dependency unit and the acute ward. Decisions to move young people were discussed in multi-disciplinary meetings and were planned ahead.
- On admission young people were allocated to a bedroom and orientated to the ward. During the first 72 hours of admission young people were not allowed to wear long sleeve tops, socks or bras while their initial risk assessment was undertaken.
- Staff discharged young people during the week and not at weekends.

The facilities promote recovery, comfort, dignity and confidentiality

- Both wards had access to a number of rooms for activities, visits, quiet rooms and lounges. There were also rooms available off the wards in the hospital. This included areas for activities, visits, therapy and education.
- Visitors to both wards could see young people in lounge or dining areas. There were no dedicated visitor rooms on either wards. However, there was a visitor room located near the two wards. Visitors under the age of 18 were not allowed on the wards to visit but this was facilitated in the visitor room adjacent to the ward.
- There was a phone on each of the wards in a private room so young people could make telephone calls. Mobile phones were not allowed on the wards and kept in a safe locker. Young people could call their relatives in the evenings from one of two telephone rooms. Internet access was available in the school and was supervised, however, one patient told us that all personal emails were blocked.
- Young people on both wards had access to a secure garden. Young people on Upper court were required to take a complicated route through the downstairs ward and past kitchen areas. A procedure was used to ensure the journey was safe, but this required a number of staff, so access was limited. The garden was a large space covered with Astroturf, however, there was no seating.
- Staff supported young people at meal times. Young people told us the food was of good quality and menu choices were offered. Menu choices were offered the day before.
- Cold drinks were available on both wards in the dining room areas which were unlocked. Hot and cold drinks were available on request.

- Young people were able to personalise their bedrooms. Some rooms were personalised extensively with books, posters and toys. We saw on our ward tours that not all rooms were personalised. Staff told us this was the choice of the young person. Young people we spoke with confirmed they were able to personalise their bedrooms.
- On admission to the ward young people had their personal possessions signed in and logged. Young people were not able to keep all items in their bedroom but had a locker to securely store possessions. Clothes were not allowed in the young people's rooms. This was a blanket rule across the two wards.
- Both wards had an occupational therapist who provided activities throughout the week. An occupational therapy timetable was available on both wards. This included ward based activities and trips including playing golf and bowling. The occupational therapist on Garden court had recently brought a PlayStation console for the ward so they could use it for singing and dancing. This was in response to patient requests. The occupational therapist told us activities were based on the views of the young people and wanted them to lead their choice of activity.
- Young people told us staff consulted them before sharing any information with their relatives or other agencies.
- Young people were provided with education during term time on weekdays. Young people from Garden court had three hours of education in the morning. Young people from Upper court had three hours of education in the afternoons. The school was well resourced. There was a head teacher, deputy head, two teaching assistants, one English teacher, one Maths teacher and an arts and languages teacher. Teaching staff told us they had good relationships with nursing and medical staff and were kept up to date on a daily basis about risks. Teaching staff attended CPAs and ward rounds and were considered part of the multi-disciplinary team. The school was not registered with Ofsted. The school was being refurbished to meet the standards of Ofsted and would then be registered. We were told young people had gained qualifications from the school. The school liaised with the schools of young people and work was sent to young people on the wards from there the schools they previously attended.
- All young people we spoke with told us they felt safe on both wards.
- Young people told us that staff were considerate and accommodating of their individual preferences and choices. For example one young person preferred to be called by a different name and staff did this.

Meeting the needs of all people who use the service

- Both wards provided access for young people who had disabilities. Staff told us about previous admissions of young people who were blind or deaf. Adjustments had been made and interpreters had been used. Staff told us each individual admission would be assessed and if a young person was referred and their needs could not be met they would be referred to a more appropriate hospital within the Priory group.
- Leaflets were widely available to young people and at their request. There were easy read leaflets available for young people with information about medication and treatments. There was information about how to raise complaints displayed on both wards. Other information leaflets available included information about mental health, cognitive behaviour therapy (CBT), dialectical behaviour therapy (DBT), thinking skills mindfulness and medications. Information was available in other languages on request. Interpreting services were available.
- Staff identified dietary requirements of young people when admitted to the wards. Any dietary requirements were discussed with the hospital kitchen so arrangements could be made for cultural and religious food preferences. Arrangements were also made for young people who may have allergies or require gluten free options. Ticehurst had been awarded a food hygiene rating of five (very good) by Rother District Council in August 2015.
- There was a multi faith room available to both wards. Young people we spoke with also confirmed they could attend church services if they wished.
- One young person told us they had a specific allergy to a food product. Staff had become aware of this during

admission and ensured that food deliveries to the service were not cross contaminated for that person. This was evidenced by a care plan around the separation of food for that person.

- Relatives of young people were able to attend care programme approach (CPA) meetings in person or buy telephone conference call. This facility was offered as some relatives lived a considerable distance from the hospital.

Listening to and learning from concerns and complaints

- There had been seven complaints made regarding the two wards in the 12 months prior to the inspection. Five of the complaints had been upheld.
- Staff supported young people if they wanted to raise a complaint. Information on how to complain was displayed on boards throughout the wards. There was also information about how to complain in information leaflets provided to young people and their relatives upon admission. Staff reported that young people were confident in making a complaint. Young people we spoke with confirmed this. Staff we spoke with were aware of the complaints procedure and how to escalate any complaints received. Informal complaints were dealt with by the ward manager. Formal complaints were investigated by the hospital manager. We were told by young people we spoke with that complaints were dealt with quickly and they were kept informed with progress.

Are child and adolescent mental health wards well-led?

Good

Vision and values

- Staff were aware of the visions and values of the Priory Group. Staff were able to tell us the values and told us they subscribed to them. The visions and values were Priory Group wide and included putting people first, being a family, acting with integrity, striving for excellence and being positive.
- Staff told us senior managers were visible, approachable and supportive. The hospital manager operated an open door policy. We were told by staff that senior executives visit the wards and the hospital director visits weekly.

Good governance

- Staff on both wards received training applicable to their role.
- Staff on both wards were receiving regular supervision. Staff also participated in reflective practice and de-brief following incidents.
- We found substantive staffing levels were low and there had been a high turnover of staff. The hospital were mitigating this risk through building links with local agencies and block booking staff to cover shifts. Senior management told us staffing was a key priority for the service and a number of initiatives to attract staff were being put in place, for example relocation packages, loyalty and reward schemes. We saw that the hospital had a work force plan in place to address recruitment issues. At the time of the inspection five nurses were going through pre-employment checks.
- Incidents were reported in line with hospital policy. Senior management reviewed incidents and provided feedback and learning to staff. The Priory Group share learning from incidents at other hospitals to ensure outcomes are disseminated across the whole hospital group.
- There were comprehensive audits taking place in the hospital that related to the two wards. Audits included reducing restrictive practice, schizophrenia, restraints, Mental Capacity Act, infection control, safeguarding, risk assessment, care plans, care programme approach and observations, preventing suicide, clinical supervision and ligature audits. The CAMHS service were specifically undertaking audits on therapy sessions and groups and one to one sessions for patients with primary nurses.
- Ward managers and senior team leaders across the hospital fed back to the management team each day about the staffing levels and incidents on the ward. This ensured that there was communication on ward based issues up and across. Different wards in the hospital were able to support each other when needed.

Good

Child and adolescent mental health wards

- Ward managers had ward clerks to assist with administrative duties.
- Staff had the ability to submit items to the overall hospital risk register. Any issues submitted to the risk register would be discussed in governance meetings. High risk items would also be put on the overall Priory Healthcare division risk register.
- There were quality walk rounds the wards once per week. Staff from other services sometimes completed these and staff from Ticehurst were able to do quality walk rounds in other CAMHS services within the Priory group. This was a form of peer review where learning from other services could be shared.

Leadership, morale and staff engagement

- The two wards had a low sickness rate of 6% for the previous 12 months. Staff retention had been an issue and there had been a turnover rate of 47%
- Staff told us that working on the two wards had, at times, been challenging over the past year. Despite this staff felt the service was improving.
- Staff were aware of the hospital whistleblowing policy and the process to follow. Staff told us they felt comfortable to use the process if they were required to do so.
- Morale among staff we spoke to was high. Staff were dedicated to the young people and providing high quality care. Staff felt listened to and involved in decisions about the wards and hospital. The hospital had held listening events to capture the views of staff.
- Staff told us the multidisciplinary team (MDT) was effective and worked well together. Staff of all grades told us they felt listened to in MDTs and their views and contributions were valued.
- There were staff notice boards and also a staff newsletter to promote engagement with staff members. There was also a "you said, we did" notice board for staff to notify them if any changes the organisation had made in response to feedback.
- Staff felt there was an effective MDT and that staff worked well together across the hospital. Staff felt they provided good patient care that gave them good outcomes.

Commitment to quality improvement and innovation

- The CAMHS ward were members of the Quality Network for Inpatient CAMHS (QNIC) and were in the process of going for accreditation.
- The wards had developed a bespoke training package called the CAMHS rolling programme. This had been developed to address a gap in training relating to working within child and adolescent mental health. Staff spoke very highly of this initiative and how it had developed there skills and confidence when working with young people.

Outstanding practice and areas for improvement

Outstanding practice

The CAMHS ward were members of the Quality Network for Inpatient CAMHS (QNIC) and were in the process of going for accreditation.

Areas for improvement

Action the provider MUST take to improve

The provider must review arrangements around emergency response to the Lodge and arrangements about a defibrillator.

The provider must review mixed gender accommodation on Highlands ward to comply with guidance on gender segregation.

The provider must ensure incident reports on the long stay rehabilitation wards have sufficient detail and investigations and information about lessons learnt are available.

The provider must ensure daily health monitoring checks are undertaken.

Action the provider SHOULD take to improve

Child and Adolescent Mental Health wards

The provider should review the temperature throughout both wards.

The provider should review ligature points throughout both wards

The provider should review the use of blanket restrictions on both wards.

Acute wards

The provider should ensure that all staff are competent in completing the various safety checks and are aware of the location of safety equipment.

The provider should ensure their ligature risk audit identifies level of risk accurately.

The provider should ensure call alarms are available for patients in communal bathrooms.

The provider should ensure that items, such as spare clothing, are available to maintain the dignity of patients.

The provider should improve patient's access to outside areas.

The provider should ensure lockable spaces are available in all bedrooms

Rehabilitation and Recovery wards

The provider should ensure all staff receive regular supervision.

The provider should improve feedback provided to staff following safeguarding referrals and incidents.

The provider should review consistency between paper and electronic records and staff access to electronic records.

The provider should ensure there is sufficient meaningful activity on Highlands and the Lodge.

The provider should review staff knowledge around the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards.

The provider should ensure patients are involved in their care plans.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Highlands ward did not have a dedicated female only lounge. We were told by staff that the multi-faith/quiet room on the first floor could be used as a female only lounge on request. This arrangement was not appropriate as the room did not provide a TV, books or any other stimulating activities. We did not consider that Highlands met the Department of Health guidance on mixed sex accommodation. This is a breach of Regulation 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was no defibrillator on the Lodge. Response time to an emergency drill was well in excess of Royal College of Psychiatry guidelines. The time from the first response call to the presentation of the defibrillator in the correct room was 10 minutes and 14 seconds. This is well in excess of the recommended guidelines of three minutes. This is a breach of Regulation 12 (2) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Accommodation for persons who require treatment for substance misuse

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

The long stay rehabilitation wards did not have appropriate systems in place to monitor specific risks to their patient group. The wards accommodated several patients over the age of 65. However, we saw only two completed Malnutrition Universal Screening Tool (MUST) forms, which were out of date. There was a lack of evidence that the wards effectively monitored and managed the risks associated with changes in body mass.

The incident reports we looked at on the long stay rehabilitation wards had very little information relating to the incident or what outcomes or investigations had been carried out. There was also no information lessons had been learnt. Some incidents had been recorded under the wrong ward name.

This is a breach of Regulation 17 (1) (2) (c)