Nightingale Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated the Nightingale Hospital as **good** overall because:

- When we inspected the Nightingale Hospital in January 2018, we rated the hospital as requires improvement. At the current inspection, we conducted a comprehensive inspection and rated all core services as Good. We did not inspect the children and adolescent mental health (CAMHS) ward, which had been closed since December 2017 as the provider submitted evidence that they were no longer providing this service.
- The provider had made significant changes to address areas of concern highlighted at the previous inspection in January 2018. A new hospital director was in post and he had recently introduced the roles of staff and patient representatives. They met regularly with the senior management team to bring about improvements at the hospital.
- At the previous inspection in January 2018 we found that there were insufficiently robust governance and quality assurance processes in place to identify areas for improvement promptly. At the current inspection we found that the hospital director had identified immediate challenges relating to the facilities and nurse leadership, and had introduced the posts of head of facilities, and ward manager to address them. The hospital managers were undertaking more audits to monitor quality across the hospital. They had also undertaken a review of procedures and processes to improve systems to prevent illicit substances from being brought into the hospital. Improvements had been made to the frequency and quality of searches, including a visit by specially trained sniffer dogs. We also found improvements in ensuring were aware of the learning from incidents across the hospital, staff recruitment checks and protocols for risk assessment prior to opening, closing or relocating wards, as required at the previous inspection.
- At our previous inspections in January 2018 and February 2017, we found that the hospital did not have an effective system in place for staff to alert other staff when they needed urgent assistance, and staff were not aware of the ligature point risks on their wards. At the current inspection we found that staff had been provided with personal alarms, and significant maintenance work was being undertaken to reduce ligature risks. Staff were aware of ligature risks as specified in the ligature risk assessment for each ward, and how to mitigate these risks.
- At the previous inspections in January 2018 and February 2017, we found that staff had insufficient training in their roles supporting patients with addictions and eating disorders, and did not have annual appraisals. This had improved at the current inspection, and we found that staff were now clear about the validated tools to use for patients on detoxification from different substances. They were also receiving annual appraisals. Staff were also ensuring that patients were always prescribed and administered medicines in line with national guidance, as required at the previous inspection.
- At the previous inspection in January 2018, we found that clinic rooms were not always clean, and staff could not access the most recent infection control audit. There were also gaps in completing action identified at the most recent fire safety assessment. At the current inspection, we found that all clinic rooms that were in use were clean, and there were records of when routine cleaning tasks were undertaken. Staff had access to the most recent infection control audit, and all actions from the current fire risk assessment had been completed.
- At the previous inspection in January 2018, we found that patient care plans were generic and patients had not been involved in the development of their care plan. At the current inspection we found that care plans were individualised and had clear input from patients. We also found that on the specialist eating disorders ward, informal patients were now clear about their right to leave the ward, and patients were assessed for their risk of developing pressure ulcers, as required at the last inspection.
- At our previous inspections in January 2018, and February 2017, we found that, on the mixed sex acute ward, there was no provision for a female only lounge. During the current inspection, we found that patients

Summary of findings

on this ward were risk assessed, and could be relocated to a single sex ward if required. Female patients on the mixed sex ward were able to access a female only ward on the first floor.

- At the previous inspection in January 2018 we found that complaint responses were not consistently of a high standard. During the current inspection we found that complaint responses were appropriately worded, addressed each area of concern, and highlighted the next steps to take if the complainant was unsatisfied.
- Weekly timetables for patients on each ward included a range of activities that supported the recovery and wellbeing of patients. Patients gave very positive feedback about staff and we saw staff were supportive and kind when interacting with patients. There were enough medical, nursing and therapeutic staff to provide care and treatment to patients and meet with them regularly for one-to-one support.
- On the eating disorder ward relatives and carers were offered a fortnightly support and education group. On the substance misuse ward, monthly family days were arranged for patients' relatives to attend, and a free aftercare weekly session was provided for patients on discharge from the ward.

However:

- Staff were not fully implementing procedures to prevent banned items such as plastic bags from being brought onto the wards. Plastic bags had been banned following a serious incident at the hospital. Staff told us that they were not always offered a debriefing session and support following a serious or challenging incident.
- Day patients on the eating disorders ward did not always have current risk assessments and care plans in place to ensure their safety and wellbeing. Discharge plans for patients with eating disorders did not always include sufficient detail including future options for support. There was also no system in place for reviewing any blanket restrictions on the wards, such as locking laundry and activity room facilities when not in use. The hospital did not have a smoke-free policy, in line with best practice guidance.
- Although staff had received specialist training in addictions and eating disorders, nursing competencies for staff working on the addiction unit and those for the eating disorder service were not specific to the care of patients with those particular needs to ensure that staff understood the specialist training they received. Staff did not have any training in working with patients who have autism, to ensure that patients with autism received appropriate support.
- There was no system in place to check mattresses and all soft furnishings in the hospital on a regular basis, and record when they were deep-cleaned to ensure appropriate infection control.
- The route taken by patients on the eating disorder ward to access the hospital restaurant, needed to be reviewed, to ensure that it did not impact on their comfort and dignity. Patient records were not always being stored in locked cabinets when they were not in use, which could potentially breach patient confidentiality
- Staff on the wards were unable to access the results of recent audits, and there was no clear evidence of changes made as a result. Staff meetings were not always held on a regular basis including standard agenda items related to quality and safety, and staff were not always able to access a clear record of the minutes of the last meeting. In addition, staff did not always have easy access to legible, accurate and up to date information about patients when they are admitted to the service, and at shift handovers.

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	The hospital had taken action to address areas highlighted as a concern in the last inspection in January 2018. This included taking steps to address environmental risks, with significant work undertaken to reduce ligature risk areas on each ward, personal alarms provided to staff, improved infection control protocols, and addressing actions from the hospital's fire safety assessment. The provider put in place systems to ensure that staff were made aware of lessons learned from incidents, and staff had regular supervision and appraisals. Improvements were made to the prescription, storage and administration of medicines. There was an improvement in recording patients' involvement in the development of their care plans. However: Staff were not fully implementing procedures to prevent banned items such as plastic bags from being brought onto the wards. Staff did not have access to the results of recent audits on the wards, and there were no regular checks of mattresses and soft furnishings on the wards to ensure good standards of infection prevention and control.
Specialist eating disorders services	Good	The hospital had taken action to address areas highlighted as a concern in the last inspection in January 2018. This including taking steps to address environmental risks, with significant work undertaken to reduce ligature risk areas on each ward, personal alarms provided to staff, and improved infection control protocols. The provider put in place systems to ensure that staff were made aware of lessons learned from incidents, and staff had regular supervision and appraisals. Staff had received training in interventions to protect patients from harm. The multidisciplinary team supported patient care and were able to offer a range of therapies in line with national guidance. Medical and nursing staff had a good understanding of managing patients at risk of refeeding syndrome and there were appropriate meal support plans in place for this.

Summary of findings

However:
Staff did not have access to the results of recent audits on the ward, and there were no regular checks of mattresses and soft furnishings on the wards.
Nursing competencies for the eating disorder ward were not specific to the care of patients with eating disorders.
Day patients on the ward did not always have a current risk assessment and care plan, there was no access to fresh air on the ward, and access to the restaurant from the ward involved some difficulties.

Substance misuse/ detoxification

Good 

The hospital had taken action to address areas highlighted as a concern in the last inspection in January 2018. This included taking steps to address environmental risks, with significant work undertaken to reduce ligature risk areas on each ward, personal alarms provided to staff, improved infection control protocols, and addressing actions from the hospital's fire safety assessment.
The provider put in place systems to ensure that staff were made aware of lessons learned from incidents, and staff had regular supervision and appraisals.
Staff had received training in interventions to protect patients from harm, including the provision and use of naloxone, and action to take in the event of an alcohol withdrawal seizure. Staff understood how to use the validated tools for patients undergoing detoxification from prescribed drugs and alcohol. There were also improved protocols for ensuring that patients undergoing detoxification were protected from harm, including better physical health monitoring.
Improvements were made to the prescription, storage and administration of medicines.
There was an improvement in recording patients' involvement in the development of their care plans.
However:
Staff did not have access to the results of recent audits on the wards, and there were no regular checks of mattresses and soft furnishings on the wards to ensure good standards of infection prevention and control.
Nursing competencies for the addiction unit staff were not specific to the care of patients with substance misuse issues.

Summary of findings

Staff meetings were not always held on a regular basis or include standard agenda items related to quality and safety. Staff were not always able to access a clear record of the minutes of the last meeting.

Summary of findings

Contents

Good

Nightingale Hospital

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

Summary of this inspection

Background to Nightingale Hospital

Nightingale Hospital is an independent hospital that provides mental healthcare and treatment for people who may or may not be detained under the Mental Health Act 1983. The hospital offers general psychiatry, eating disorder and addiction treatment for adults as both inpatients and outpatients. The hospital also offers addiction, general psychiatry and eating disorder treatment to young people (adolescents) as outpatients services only.

The service provides three acute wards for adults of working age, a substance misuse and detoxification ward and a specialist eating disorder service for adults. The child and adolescent mental health ward had been closed since December 2017 and the hospital was no longer providing this service. Wards provide mixed sex accommodation, apart from the acute wards on the first and second floors. The hospital has 80 beds over the six wards.

At the time of our visit, there were 36 patients admitted to the hospital over six wards, with one patient on the eating disorder ward, one patient on the substance misuse ward and 34 patients on the general acute wards. During the inspection we also spoke with day patients at the eating disorder unit and case-tracked patients who had recently been admitted to the eating disorder and substance misuse wards.

The fourth floor of the hospital, which was a substance misuse ward, was closed for refurbishment. The child and adolescent mental health ward was closed, and the eating disorder ward was located in a separate nine-bedded three-storey building. The eating disorder unit also accepted day patients who did not sleep on the unit.

The ground floor ward was an 11-bed acute ward for adults of working age. The first floor had a 14-bed and a six-bed ward for adults of working age. The third and fourth floors were a 16-bed substance misuse and detoxification ward for adults.

There are over 55 consultant psychiatrists who have practicing privileges at the Nightingale Hospital. This means that they can admit patients they see in the community to an inpatient bed and remain their consultant while the patients are on the ward.

We last inspected the Nightingale Hospital in January 2018. The overall rating for the hospital at that time was requires improvement.

Our inspection team

The team that inspected the Nightingale Hospital comprised 11 people. This included one CQC inspection manager, four CQC inspectors, an assistant inspector, four specialist advisors (consisting of a consultant psychiatrist, and three senior nurses), and an expert by experience. The expert by experience had experience of using or caring for people who used similar services.

Why we carried out this inspection

We conducted an unannounced focussed inspection of the Nightingale Hospital ('the hospital') on 15, 16, 19 and 21 January 2018 to check on compliance with breaches of regulations from the previous inspection, which took place in February 2017. Following the January 2018 inspection, we rated the service as **Requires improvement** overall.

We rated acute wards for adults of working age and specialist eating disorder wards as **Requires improvement** overall. We rated acute wards for adults of working age as **Requires improvement** for safe and effective and **Good** for caring, responsive and well-led. We rated specialist eating disorder wards as **Requires**

Summary of this inspection

improvement for safe, effective, responsive and well-led, and **Good** for caring. We inspected but did not rate the substance misuse wards. We did not inspect children and adolescent mental health wards, which retained its ratings of **Requires improvement** overall.

Following the January 2018 inspection, we told the provider it must make the following actions to improve:

- The provider must ensure that staff are provided with an alarm system to summon assistance in an emergency.
- The provider must ensure that staff are clear about the ligature risks and management plans on each ward, in order to do all that is reasonably practical to mitigate risks.
- The provider must ensure that patients are prescribed and administered medicines at the correct dose, and that relevant medicines are stored in a locked fridge, oxygen is labelled appropriately and medicines and devices are monitored and maintained appropriately.
- The provider must fully address overdue actions from the fire risk assessment, as well as the fire risk posed by patients placing towels over their bedroom doors.
- The provider must ensure infection control standards and requirements are adhered to and all areas of the wards are clean.
- The provider must ensure that the ward furniture can be effectively cleaned.
- The provider must ensure appropriate food hygiene by monitoring the temperatures of the refrigerators for storing food and beverages in patient areas and taking action to ensure they remain within range.
- The provider must ensure that on the substance misuse wards, patients undertaking detoxification, are protected from harm, through restrictions on leave from the hospital and physical health monitoring.
- The provider must ensure that patients on detoxification programmes have an early exit plan specifying action they should take if they leave treatment early.
- The provider must ensure that staff working on the substance misuse wards, are trained in interventions to protect patients from harm, including provision and use of naloxone and action to take in the event of an alcohol withdrawal seizure.
- The provider must ensure that all the concerns raised in complaints are addressed, that written complaints receive a written response, that the language used in the complaints response is appropriate and that the complainant always knows how to escalate their concerns if they are not satisfied with the response.
- The provider must ensure that there are robust governance and quality assurance processes in place to identify areas for improvement in a timely manner.
- The provider must ensure an appropriate level of planning and risk assessment takes place when a ward moves location.
- The provider must ensure that there is an effective system in place to ensure staff know about and learn from incidents.
- The provider must ensure that staff team meetings are held on a regular basis and include standard agenda items related to quality and safety.
- The provider must ensure that staff receive sufficient training in their roles to support patients with addictions and eating disorders. They must be clear about the validated tools to use for patients on detoxification from different substances.
- The provider must ensure that staff had access to regular appraisals.
- The provider must ensure that they complete the necessary recruitment checks for all staff, including obtaining and verifying two written references.
- The provider must ensure that informal patients on the eating disorders ward have clear information about their right to leave the ward.
- The provider must ensure that patients on the eating disorders ward are able to freely access fresh air on a daily basis.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 11 Need for consent

Regulation 12 Safe care and treatment

Regulation 16 Receiving and acting on complaints

Regulation 17 Good governance

Regulation 18 Staffing

Regulation 19 Fit and proper persons employed

Summary of this 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 visiting, we reviewed a range of information we held about the Nightingale Hospital and a provider request for information about the service.

During the inspection visit, the inspection team:

- visited six wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 14 patients who were using the service
- interviewed the hospital director, compliance manager, and nursing services manager
- spoke with the charge nurse or senior staff on each of the wards
- spoke with 23 other staff members; including doctors, nurses, occupational therapists, a dietitian, therapists, a pharmacist, maintenance and domestic staff
- attended a bed management meeting
- looked at 21 care and treatment records of patients
- checked medication management on all of the wards, including 24 prescription charts
- reviewed five complaint records
- reviewed systems for monitoring consultants who have practicing privileges and eight employment files for recently recruited staff
- reviewed fire safety documentation as well as other health and safety records
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

We spoke with 14 patients who were using the inpatient or day patient facilities at the time of the inspection.

Patients were very positive about the staff in all services, and said they listened to patients and family members and acted promptly to meet their needs. Patients said staff were very approachable and had a good understanding of their needs, making time to support them individually.

Patients we spoke with were satisfied with the amount, variety and quality of the therapeutic support they received and said that the therapies on offer had a positive impact on their recovery.

Patients told us they felt safe on the wards, and were involved in making decisions about their care and were offered a copy of their care plan. They said that the environment was comfortable and clean and were satisfied with the choice of meals provided.

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?

Good

We rated safe as **good** because:

- At our previous inspections in January 2018, February 2017, and October 2015, we found that the hospital did not have an effective system in place for staff to alert other staff when they needed urgent assistance. At the current inspection we found that staff had been provided with personal alarms.
- At our previous inspections in January 2018, and February 2017, we found that there were ligature risks throughout the wards and staff were unable to explain how these would be mitigated. At the current inspection we found that maintenance work had been undertaken to reduce ligature risks and further work was planned. Staff were aware of ligature risks as specified in the ligature risk assessment for each ward, and how to mitigate these risks.
- At our previous inspections in January 2018, and February 2017, we found that, on the mixed sex acute ward, there was no provision for a female only lounge. During the current inspection, we found that patients on this ward were risk assessed, and could be relocated to a single sex ward if required. Female patients on the mixed sex ward were able to access a female only ward on the first floor.
- At the previous inspections in January 2018, and February 2017, we found that staff had insufficient training in their roles supporting patients with addictions and eating disorders. At the current inspection we found that staff had received relevant training in these areas to protect relevant patients from harm, including patients at risk of an opiate overdose.
- At the previous inspection in January 2018, we found that clinic rooms, including the fridges, which contained patient medication, were not always clean, and staff could not access the most recent infection control audit for the hospital. At the current inspection, we found that all clinic rooms that were in use were clean, and there were records of when routine cleaning tasks were undertaken. Staff were able to access the most recent infection control audit, indicating actions to be taken for effective infection control.
- At the previous inspection in January 2018, there was no clear record of actions to address the issues identified as part of a recent fire safety assessment. During the current inspection we found that a new fire safety audit had been undertaken with all actions addressed as appropriate.

Summary of this inspection

- At the previous inspection we found that patients were not always prescribed and administered medicines in line with national guidance. This was no longer an issue at the current inspection.
- At the previous inspection in January 2018, staff did not check fridge temperatures in the patients' kitchen consistently. This was now taking place.
- At the previous inspection in January 2018, we found that staff on the eating disorders ward did not assess patients for risk of pressure ulcers. This was now being undertaken for patients of very low weight as appropriate.
- At the previous inspection in January 2018, we found that staff were not sufficiently made aware of the learning from incidents across the hospital. At the current inspection we found that staff were aware of learning from incidents, and had access to lessons learnt bulletins relating to all wards in the hospital. Lessons learnt were also discussed in team meetings, supervision and staff handover sessions.
- At the previous inspection in January 2018, we found that recruitment checks were insufficiently rigorous for new staff and medical professionals. Improvements had been made since that inspection, and we found that rigorous checks were now taking place as appropriate.
- Staff assessed patients' risks on admission and staff and patients completed daily risk assessments, with plans to manage risks outlined in daily handover notes.
- Staff were trained in safeguarding and had appropriate arrangements in place for visitors, including those under 18.
- There were enough medical, nursing and therapeutic staff to provide care and treatment to patients and meet with them regularly for one-to-one support.

However:

- On the acute wards staff were not fully implementing procedures to prevent banned items such as plastic bags from being brought onto the wards. Plastic bags had been banned following a serious incident at the hospital.
- Staff were not always offered a debriefing session and support following a serious or challenging incident.
- There was no system in place to check mattresses and all soft furnishings in the hospital on a regular basis, and record when they were deep-cleaned to ensure appropriate infection control.
- Day patients on the eating disorders ward did not always have current risk assessments in place to ensure their safety.

Summary of this inspection

- On the eating disorders ward there was no system in place for reviewing any blanket restrictions on the wards, such as locking laundry and activity room facilities when not in use.

Are services effective?

Good

We rated effective as **good** because:

- At the previous inspections in January 2018 and February 2017, we found that the number of staff who had received an appraisal was not adequate. At the current inspection, we found that there had been a significant improvement in the number of staff who had received an appraisal.
- At the previous inspections in January 2018 and February 2017, we found that staff had insufficient training in their roles supporting patients with addictions and eating disorders. This had improved at the current inspection, and we found that staff were now clear about the validated tools to use for patients undergoing detoxification from different substances.
- At the previous inspection in January 2018, we found that on the specialist eating disorders ward, there was no distinction between the way formal and informal patients were treated in relation to leave arrangements. At the current inspection we found that informal patients were clear about their right to leave the ward.
- At the previous inspection in January 2018, we found that patient care plans were generic and patients had not been involved in the development of their care plan. This had been addressed by the time of the current inspection with clear input from patients recorded in their care plans, addressing mental health and physical health problems.
- We found improvements in the recording of decision specific mental capacity assessments for patients and improved recording of induction training provided to new staff.
- There was good communication between the multi-disciplinary team and staff received regular supervision sessions. Patients had access to a range of therapies in line with national guidance.

However:

- Nursing competencies for the addiction unit were not substance misuse specific, and those for the eating disorder service were not specific to the care of patients with eating disorders. This meant that managers could not be sure that staff had embedded the specialist substance misuse and specialist eating disorders training.

Summary of this inspection

- Staff did not always have easy access to legible, accurate and up to date information about patients when they are admitted to the service, and at shift handovers.
- Staff did not have any training in working with patients who have autism, which meant that they could not always provide appropriate support for patients with autism.
- Current care plans were not always in place for day patients in the eating disorder service.
- The hospital did not have a smoke-free policy, in line with best practice, although smoking cessation support was available.

Are services caring?

Good

We rated caring as **good** because:

- Patients gave very positive feedback about staff and we saw staff were supportive and kind when interacting with patients. Patients said staff were approachable and had an understanding of their individual needs.
- Patients told us and records showed that patients were involved in decisions about their care, as well as family members when the patient consented.
- On the eating disorder ward relatives and carers were offered a fortnightly support and education group.
- On the substance misuse ward, monthly family days were arranged for patients' relatives to attend, and a free aftercare weekly session was provided for patients on discharge from the ward.
- Patients could give feedback about their care. A new role of patient representative had been introduced to ensure that patients had more say about the way the hospital was managed.
- Patients had access to an independent advocate and knew how an advocate could support them to be involved in their care and decision making.

However:

- Patient records were not always being stored in locked cabinets when they were not in use, which could potentially breach patient confidentiality.

Are services responsive?

Good

We rated responsive as **good** because:

- Patient bedrooms were well furnished and decorated and all had en-suite facilities. Patients could store their possessions safely on the ward.

Summary of this inspection

- There was an accessible toilet and lift available for patients with a disability or who used a wheelchair due to low weight.
- Patients spoke positively about the choice of food provided within the hospital.
- Staff discussed patients' length of stay from the point of admission and patients were made aware of the funding packages, which applied to them.
- There were daily visiting times and staff supported patients to maintain relationships with friends and family whilst they were on the wards.
- Weekly timetables for patients on each ward included a range of activities that supported the recovery and wellbeing of patients.
- At the previous inspection in January 2018 we found that not all complaint responses addressed all areas of complaint, a small number were not appropriately sympathetic, and responses did not include information on the next steps to take if unsatisfied with the response. During the current inspection we found that complaint responses were appropriately worded, addressed each area of concern, and made clear the next steps to take if the complainant was unsatisfied.

However:

- There was no outside space that could be accessed directly from the eating disorders ward. To access fresh air, patients had to ask staff to unlock two doors and leave the ward.
- The route taken by patients on the eating disorder ward to access the hospital restaurant, needed to be reviewed, to ensure that it did not impact on their comfort and dignity.
- Discharge plans for patients with eating disorders did not always include sufficient detail about patients' strengths, and future options for support.

Are services well-led?

Good

We rated well-led as **good** because:

- The provider had made significant changes to address the areas of concern highlighted at the last inspection in January 2018.
- A new hospital director was in post and he had introduced the roles of staff and patient representatives and meetings with the senior management team to bring about improvements at the hospital.
- At the previous inspections in January 2018 and February 2017, we found that staff were not receiving annual appraisals. This had improved at the time of the current inspection.

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- At the previous inspection in January 2018, we found that there were insufficiently robust governance and quality assurance processes in place to identify areas for improvement promptly. At the current inspection we found that the hospital director had identified immediate challenges relating to the facilities and nurse leadership, and had introduced the posts of head of facilities, and ward manager to address them. The hospital was undertaking more audits to monitor quality across the hospital.
- At the previous inspection in January 2018, we found that systems to prevent illicit substances being brought into the hospital were not sufficiently robust. A review of procedures and processes was undertaken since the inspection, with improvements made to the frequency and quality of searches, including a visit by specially trained sniffer dogs.
- At the previous inspection in January 2018, we found that there had been insufficient planning and risk assessment prior to the relocation of the eating disorder ward to a different building. Since then, the provider had put in place a checklist of protocols for opening and closing wards.
- At the previous inspection in January 2018, we found that learning from incidents was not embedded in ward systems. At the current inspection we found that staff discussed learning from incidents in supervision and at handover and team meetings. They also had access to a bulletin with lessons learnt from incidents across the hospital.
- The provider had improved the level of detail in notifications to the CQC about incidents.
- The staff we spoke with were proud to work at the hospital and said they worked well with colleagues to support patients and their individual needs.
- Staff had access to the equipment and information technology needed to do their work.
- The provider routinely collected feedback from patients and carers in order to identify where improvements were needed across the hospital.

However:

- Staff meetings were not always held on a regular basis including standard agenda items related to quality and safety, and staff were not always able to access a clear record of the minutes of the last meeting.
- Although we found evidence that a range of relevant audits were undertaken by staff on a regular basis. Staff on the ward did not know, or have access to the results of recent audits, and there was no clear evidence of changes made as a result.

Detailed findings from this inspection

Mental Health Act responsibilities

Staff had received training in the Mental Health Act 1983 (MHA). Staff showed a good understanding of the MHA, Code of Practice and guiding principles.

Informal patients had completed an informal rights form on admission, informing them of their legal right to leave the hospital and to refuse treatment.

Staff had recorded that detained patients were being informed of their rights under section 132 and were having that explanation repeated as required. The papers relating to detention were in good order, and checked by the administrator and the medical director.

There was an independent mental health advocacy service provided and we saw evidence that all detained patients were referred to this service.

The eating disorders ward was a locked environment, with two doors that could only be opened by staff. Since the previous inspection, staff had provided a notice on the door to inform informal patients that they had the right to leave the ward.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were trained in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). There had been no DoLS applications made for patients at the time of the inspection.

The service completed an assessment of each patient's capacity to consent to admission and treatment during the initial assessment. The assessment form asked whether there were reasons to suggest the patient may lack capacity. If there were doubts about capacity, the doctor and nurse completing the assessment were required to complete a thorough capacity assessment form and inform the hospital compliance manager.

Staff said that the service occasionally admitted patients with impaired capacity due to alcohol intoxication. In these situations, staff would monitor the patient to ensure their safety and wait for the patient to regain capacity once the effects of alcohol had worn off. The hospital policy stated that if a patient entered the hospital, this could be interpreted as implied consent to admission. The policy also stated that any action on behalf of a person who lacks capacity, even temporarily, must be completed in the person's best interests.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

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

Good

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

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

Requires improvement

Safe and clean environment

Safety of the ward layout

Staff assessed risks to patients and staff arising from the layout of the ward and mitigated these with regular checks of the ward environment, individual patient risk assessment and by observing patients.

There was an up to date assessment of environmental risks on each ward, covering the risks from potential ligature points and other hazards and blind spots on the ward. Since our previous inspection in January 2018, the provider had improved the safety of acute wards through changes to the environment. For example, the provider altered bathroom doors to make them safer. A risk management plan for each ward explained how staff were to mitigate the risks to patients. Staff said they were aware of this document and the risks on the ward and that these were explained to any new permanent, bank or agency staff. For example, on the second floor, staff kept a small room, used as an office, locked when not in use because the light fittings could be used as a ligature anchor point. Ligature anchor points were noted on the checklist, which staff used each hour. There were safety mirrors in the ward corridors to allow staff to more easily observe all parts of the ward. Work to improve the safety of the wards was ongoing. For example, on the second floor, work to box in televisions was taking place.

Twice each day, nursing staff held shift handover meetings, which included a review of summary information about each patient including any identified risks, such as the risk of self-harm. Risks were classified as low, medium or high. For patients at heightened risk staff kept close observation of the patient. For example, staff were carrying out one to one observations of a patient who was at high risk of attempting to self-harm.

The service complied with guidance on eliminating mixed sex accommodation. The second-floor ward was for male patients. Wards1A and 1B were for female patients. The ground floor ward was for both male and female patients. All patients in the service had their own bedroom with attached bathroom. Female patients on the ground floor could use an all-female lounge on the first floor if they wished. Staff risk-assessed patients and moved patients from the ground floor ward to an all-male or all-female ward to mitigate risks when this was necessary.

Following our previous inspection in January 2018, we told the provider they must improve the alarm system. At this inspection, we found that the provider had addressed this. Staff now carried personal alarms.

Following the inspection in January 2018, we told the provider they must fully address overdue actions from the previous fire risk assessment. Since then, the provider arranged for another independent fire risk assessment of the hospital, which took place in July 2018. The provider had acted to address the issues identified in this report. The service held regular fire drills. Fire blankets and fire extinguishers were available on the wards.

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

Good

The service planned for emergencies and staff understood their roles if one should happen. Staff told us that simulation training events took place so they could practice how to respond to an emergency.

Maintenance, cleanliness and infection control

Patients were cared for in clean and well-maintained wards. At our previous inspection in January 2018, we told the provider they must meet infection control standards and ensure all parts of the wards and ward furniture were kept clean. At this inspection, we found improvements.

Since the previous inspection, the wards had introduced mattress and pillow covers in all bedrooms. Staff ordered new mattresses when required. Staff said soft furnishings were deep cleaned. The provider was in the process of replacing the furniture across the hospital. We saw that wards were clean throughout and that furniture, including mattresses and carpets were clean. However, there was no record of regular mattress checks taking place. Cleaning records showed that domestic staff cleaned all areas of the ward according to a schedule. Each ward had a designated infection control champion.

Staff made checks of the ward environment and any maintenance issues were put right. Staff said the in-house maintenance team responded quickly to any problems.

Seclusion rooms

There were no seclusion rooms in the service.

Clinic rooms and equipment

At our previous inspection in January 2018, we identified breaches of regulation in relation to clinic rooms and equipment. We told the provider that they must ensure that relevant medicines were stored in a locked fridge, oxygen was labelled and medicines and devices were monitored and maintained appropriately. At this inspection, we confirmed that the provider had made the required improvements. The wards now had clean, tidy and well-equipped clinic rooms. Relevant medicines were stored in a locked fridge.

By the second day of the inspection, oxygen was labelled appropriately. Staff made the appropriate checks of equipment and fridges. Equipment was clean and well-maintained.

Each ward had easy to access emergency resuscitation equipment including a defibrillator and emergency medicines. Each week staff checked that all emergency equipment was in place and fit for use.

Safe staffing

Nursing staff

The provider specified the number of registered nurses and non-registered nurses required on each ward to ensure patient and staff safety. Safe staffing levels were maintained on the wards. The provider told us that across all acute wards on 30 November 2018 there was an establishment of 27.5 registered nurses and four non-registered nurses. At that time, there was one vacancy for a registered nurse and no vacancies for non-registered nurses. Between December 2017 and November 2018, on the acute wards the average amount of staff cover provided by bank and agency staff was 25%, consisting of 18% bank and 7% agency staff. Patients told us that the use of agency and bank staff was higher at weekends and overnight. Staff told us shifts were always fully staffed. Staffing levels varied according to the size of the ward. For example, Ward 1A had a minimum of two members of staff including one registered nurse. Ward 1B had one registered nurse for every four patients. On the day of our inspection there were 11 patients on Ward 1B and three registered nurses and one non-registered nurse on the ward.

There were contingency plans if a ward required extra staff due to unforeseen circumstances. Senior staff and staff from other wards were available to ensure the safety of patients and staff.

Patients told us they were offered daily one to one time with a member of staff. Care and treatment records included staff notes on one to one sessions with patients. They said that when needed staff were available to escort them when they went out to appointments.

Staff teams could safely carry out physical interventions. Staff had training on this and attended an annual course to refresh their skills.

Medical staff

Staff reported that there was always sufficient medical cover, which meant a doctor could attend the ward in an emergency. Many different psychiatrists admitted patients

to the wards. These psychiatrists visited patients three times each week and were available out of hours for advice. The hospital had a doctor on site during normal working hours and there were on-call arrangements out of hours.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. The provider told us that there was an overall completion rate of 81% for mandatory training across the hospital at 30 November 2018. Courses included infection control, basic life support and fire safety.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff assessed each patient comprehensively on admission to the service and thereafter continuously reviewed and updated risk assessments. On admission, nursing staff and the ward doctor completed a handwritten booklet, which included standardised screening tools and risk assessments. Risks in relation to the patient's physical and mental health were identified and categorised as low, medium or high. There was also information on the patient's background, mental health history and reasons for admission. Staff told us that this hand-written information was difficult for them to read and potentially put at risk the transfer of timely and accurate information to other agencies.

We reviewed 12 patient records across the acute wards. Risks were assessed appropriately at the point of admission and throughout the patient's stay. For example, patients were screened for substance misuse issues on admission. Staff were alert to changes in the patient's mood and behaviour and noted new information at twice daily handover meetings. There was a daily handover meeting between therapy staff and the ward nursing team where risks were discussed.

Management of patient risk

On the acute wards, the most frequently identified risk was the risk of self-harm.

The wards had a list of banned items, which included plastic bags. Patients told us they were aware of this list. Most patients told us that staff always stopped them from bringing plastic bags on to the ward. However, one patient said that staff were aware that they brought shopping into their bedroom in plastic bags. Staff did not remove the plastic bags from the patient immediately on their return to the ward. The plastic bags were removed when staff made their next hourly check of their room. We were concerned about this, as a plastic bag had been involved in a serious self-harm incident in the service in 2017.

The provider had an ongoing programme to reduce the number of ligature anchor points in the service. The restrictions which were in place to manage patient risk did not unduly impact on patients' rights and freedom. For example, patients were not permitted to have charging cables in their bedrooms. The provider had recently installed, on each ward, a charging tower located near the nurses' station so that patients could charge their electronic devices and phones safely. Patients could use their mobile phones and there were computers available. Patients could access free wi-fi.

Use of restrictive interventions

Staff seldom used restrictive interventions. There was no seclusion room. Restraint was used rarely. From 1 June to 30 November 2018 there were 11 episodes of restraint on the acute wards. One of these episodes was a prone restraint followed by rapid tranquilisation by injection.

Staff had a good understanding of their responsibility to minimise the use of restraint and to keep appropriate records of any restraints. Staff were aware of the provider's procedures on restraint and the physical monitoring of patients after rapid tranquilisation. These procedures followed National Institute for Health and Care Excellence guidance.

Safeguarding

Staff understood multi-agency procedures to protect patients from abuse and the service worked well with other agencies to do so. The hospital had a lead for adult and children's safeguarding. Staff said the lead was readily available for advice and support.

Patients were protected from bullying and harassment whilst on the ward. Staff told us how they spoke with patients, including those with protected characteristics to ensure they felt safe and welcome on the wards. Patients said that the wards had a safe, calm atmosphere and they were certain that staff would act to prevent any bullying or harassment.

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

Good

Staff had received appropriate training on safeguarding children and adults. Children could come onto the wards but did not go into communal areas.

Staff access to essential information

Staff kept appropriate records of patients' care and treatment. Staff could easily locate records.

Whilst there was an electronic database, some records were hand written. This included admission information. Staff said that sometimes this information was difficult to read. Additionally, it made it more difficult to transfer accurate and comprehensive information on the patient when making referrals to other agencies.

Medicines management

The provider had made improvements since our previous inspection in January 2018 and the service prescribed, gave, recorded and stored medicines well. Patients received the right medicines at the right dose at the right time. Staff followed the provider's procedures in relation to the safe management of medicines. These complied with National Institute for Health and Care Excellence guidance.

At our previous inspection, we told the provider that they must ensure that medicines were prescribed, administered and stored appropriately. At this inspection, the provider had rectified these issues. Medicines that required refrigeration were now stored in a locked fridge. We did not find any out of date medicines. Patients received medicines at the correct dose and time.

We reviewed 20 prescription charts. These were accurately completed and confirmed that staff supported patients to have their medicines as prescribed.

A clinical pharmacist visited the wards at least once a week to check prescription charts and stocks of medicines. The service followed National Institute for Health and Care Excellence guidance in relation to monitoring the physical health of patients who were prescribed certain medicines.

Track record on safety

The provider provided us with information on seven incidents on the acute wards, which they classed as serious for the period I November 2017 to 30 November 2018. One of these incidents was an in-patient death and another incident was a serious attempted self-harm incident.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Staff could explain to us what incidents should be reported and knew how to make a report. Any new incidents were reported and discussed at the hospital's daily handover meeting. Charge nurses from each ward and senior managers attended this brief meeting.

At our previous inspection in January 2018, we told the provider that they must ensure that there was an effective system in place to ensure staff know about and learn from incidents. At this inspection we found improvements. There were now effective arrangements to share lessons learned across the service. The service's quality manager sent monthly data on incidents and written information on lessons learnt to charge nurses. Charge nurses then included this information in team meeting discussions and notes. Team meeting notes were circulated to staff who had not attended the meeting. Staff told us they had information about lessons learnt and knew about the serious incidents that had occurred in the service.

Staff understood the duty of candour. Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong.

Staff told us that the managers were supportive when incidents occurred and were aware that counselling and other support was available.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff assessed each patient's mental and physical health needs comprehensively on admission. We reviewed 12 care and treatment records. The ward doctor and a nurse completed a comprehensive assessment when the patient

was admitted. This was hand-written and recorded in an admissions booklet. The booklet included the reasons for the patient's admission, their mental and physical health history and current presentation, a mental state examination, a medicines review, and their personal and social details.

At this initial assessment, the doctor and nurse created a 24-hour care plan. This care plan included details of how nursing staff should support the patient, the patient's medicines and details of any leave arrangements. The therapy team assessed patients within 24 hours of admission and created a personalised and recovery-focused therapy plan. The physical health needs of the patient were fully assessed and documented on admission. There were details of the patient's blood pressure, pulse, oxygen saturation, weight and allergies nutrition and hydration needs. Staff screened patients for alcohol and substance misuse and arranged for follow up investigations and blood tests if appropriate. Staff reviewed the care and treatment for each patient every week. Staff checked the patient's vital signs at least weekly and more often if there was a medical need.

Care plans were personalised, holistic and recovery focused. Patients and staff collaborated to create care plans that met the patient's individual needs. Care plans included the patient's current mental state and mood, medicines administration, physical health monitoring, risk and safety, their therapy programme and nursing interventions. Patients and staff reviewed care plans on a weekly basis.

Best practice in treatment and care

The service delivered care and treatment in line with national guidance on best practice. The 12 care and treatment records we reviewed showed that the service provided a range of therapies, including those recommended by the National Institute for Health and Care Excellence. The therapy team arranged for each patient to attend groups and individual sessions that were suitable for them. Sessions provided included cognitive behavioural therapy, interpersonal therapy, managing anxiety and depression, yoga and art therapy. Patients could continue to attend sessions once discharged from the service if they wished. The therapy programmes were tailored to patients' individual needs including symptom management sessions.

Staff ensured that patients' physical health needs were met. Patients told us they could see the ward doctor about any health concerns or questions the nursing team could not address. Staff monitored patients' physical health, recording vital signs and reported any changes to the ward doctor for follow-up.

Patients told us that staff encouraged them to stay active, eat well and to reduce unhealthy activities such as smoking. Patients could use the gym within the service.

The service used recognised rating scales to monitor and develop the effectiveness of the care and treatment provided.

Staff in the service carried out a range of clinical audits. The compliance manager led a programme of audits. Ward charge nurses met with the compliance manager to hear about the results and feed back to teams. At the time of the inspection, there were no written outcomes or recommendations from the latest audits, which had been conducted in February 2019. We read details of care and treatment record audits, which identified gaps in the records, but there were no action plans in place to address the issues found.

Skilled staff to deliver care

The ward team had access to a full range of specialists to meet the needs of the patients. This included consultant psychiatrists, doctors, pharmacists, registered and non-registered nurses, clinical and counselling psychologists, and occupational therapists.

Staff were appropriately skilled and qualified to meet the needs of patients on an acute mental health ward. Staff had a range of experience, with some staff members working within the service for several years while others were relatively new in post.

New staff, and bank and agency staff working on the ward for the first time, were provided with induction training. They worked through an induction checklist covering ligature risks on the wards, policies, guidelines and expectations. Staff said they felt their induction equipped them to work effectively on the ward.

Most staff received monthly clinical supervision from senior colleagues. The clinical supervision rate for non-medical staff as of November 2018 was 75%. On the ground floor it was 100% in January and February 2019, on 1B it was 91% in January and 85% in February, and on the second floor it

was 57% in January and 86% in February. We reviewed six supervision records. A standard template was used for supervision. This covered areas for discussion such as wellbeing, record keeping, incidents and lessons learnt and reflection. The supervision template also covered targets for action such as training and development, policy updates and inducting new staff. Staff told us that they felt supported by their managers and able to raise any concerns via supervision. The therapists supporting the service told us they received external supervision and development in line with their specialist disciplines.

At the last inspection in January 2018, we found that the completion of staff appraisals was very low. At this inspection, we found that the rate of non-medical staff receiving appraisals as of November 2018 was 82%. Staff told us that appraisals were an effective mechanism to reflect on their work and develop their skills. Charge nurses were confident that their managers and the provider's human resources team would assist them if there were concerns about a member of staff's competence.

At the last inspection in January 2018, we found that staff team meetings were not held on a regular basis and there was no standard agenda covering learning from incidents. At this inspection, we found improvements. Staff meetings were now happening monthly. The staff meeting notes showed the meeting followed a standard format. It covered areas such as lessons learnt from incidents, team interactions, training needs, rota and staffing issues and patient feedback. Charge nurses told us that whilst team meetings were now held regularly, the fact that ward staff teams were small, meant that only about three or four staff attended the team meeting. Charge nurses therefore ensured that items covered in the team meeting were included within individual supervision meetings and team handovers, so that all members of the team were well-informed.

Multidisciplinary and interagency team work

The multidisciplinary team worked effectively to safely meet patient needs. Many different consultant psychiatrists admitted patients to the acute wards. Psychiatrists visited their patients at least three times a week. Nurses told us that, prior to meeting with their patient, the psychiatrist met with the charge nurse, or senior nurse on duty, for an update about the patient. Therapists sent psychiatrists weekly feedback about the patient. After meeting with their patient, the psychiatrist noted any changes to their care and treatment and formulated a discharge plan. We saw from care and treatment records that if there were difficulties with discharge planning, then ward staff arranged a review meeting, which involved all disciplines, to make decisions about the patient's care and treatment.

There was effective communication between therapy and nursing staff to ensure effective care and treatment. There was a daily afternoon handover meeting between the therapy department and the ward nursing team. We observed one of these meetings. All the therapists and a nurse from each ward attended. Therapy staff gave nurses a verbal report about each patient that attended any of the groups. The report covered the patient's mental state and progress, any concerns or risks, and discharge plans.

Both therapy and nursing staff told us that they found this handover very helpful as it provided information that fed into care planning and support and risk management for individual patients. For example, a therapist reported to the nurses that a patient had become distressed during the therapy session and explained the reasons for this. Nurses said they would be alert to any signs of distress and provide support to the patient on the ward.

Staff on each ward held an effective handover meeting twice a day when the day and night shifts changed over. Staff worked from a handover sheet where they recorded updates and discussed each patient. This included the patients' mental and physical presentation, progress, risk and safety concerns, leave status, observation levels, group attendance and discharge plans. Patients told us that they found that the staff coming onto a shift were always well-informed about their care and treatment and discharge plans.

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

Good practice in applying the Mental Health Act

Staff in the service complied with the requirements of the Mental Health Act. As of November 2018, 85% of staff had received Mental Health Act training. The service had a Mental Health Act lead. Staff were aware of how to access the provider's policies on the Mental Health Act and the Code of Practice on the service's intranet.

We reviewed the care and treatment records of a detained patient. Their records included a checklist completed by

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

Good

nursing staff to ensure that all appropriate action had been taken to comply with the legal guidance. For example, staff had appropriately spoken with the patient about their legal rights.

Patients told us that an independent mental health advocate regularly visited the ward and was available to them if they need to access this service. Informal patients were aware of their right to come and go from the wards as they wished.

The mental health administrator was based on site at the hospital. An audit of MHA processes undertaken in December 2018 indicated that improvements could be made in the use of the Section 5(2) holding power, to ensure that this was only used strictly in accordance with the law, with recommendations made to address this.

Good practice in applying the Mental Capacity Act 2005

Staff acted in accordance with the key principles of the Mental Capacity Act. As of November 2018, 86% of staff had completed training on the Mental Capacity Act.

The provider had a policy of the Mental Capacity Act on their intranet. Staff were aware of the policy and how to access it.

On admission, the admitting ward doctor and nurse assessed patients' capacity to consent to the admission and to make decisions about their care and treatment. Brief details of these assessments were recorded in the admissions booklet.

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

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients kindly and respectfully. Patients told us that staff were always friendly and polite. They said staff took time to get to know them and understood what type of emotional and practical support they needed. Staff could tell us about the individual needs of patients.

We observed that staff communicated well with patients and took time to answer any questions. Staff were consistently patient and calm. Staff respected patient confidentiality and did not talk about patients in communal areas. Patients told us that therapy staff were kind and supportive if they became distressed during therapy sessions. Paper care records were kept in locked cabinets. The provider had installed privacy screens on computers.

Involvement in care

Staff in the service orientated patients to the ward and the hospital. Patients told us a member of staff showed them around when they were first admitted. The service had a written leaflet for patients and carers.

Staff involved patients in planning their care and treatment. Psychiatrists met with patients about three times a week to review and plan their care and treatment. On admission, a member of the therapy team met with the patient to plan a therapeutic programme with them. Staff asked patients to complete a form each week about how they felt about their care and treatment. Care plans showed that staff spoke with patients about their care and treatment and recovery goals.

The provider had recently begun to involve patients in the development of the service. There was now a patient and management forum, which had met for the first time in February 2019. Patient representatives from each ward had attended this meeting and notes of the meeting were on display on patient noticeboards on all the wards. Wards also held weekly community meetings and patients were asked to complete a survey when they were discharged.

The service's pharmacist held a weekly session for patients where they could ask questions about medicines.

The provider commissioned an independent advocacy service. Patients told us they were aware of how to access this service if they wished.

Involvement of families and carers

Staff involved families and carers appropriately and provided them with support when needed. Staff told us they were patient-led in terms of the extent to which the patient's family was involved. Care and treatment records showed that, when a patient had given consent, staff invited the patient's family to treatment reviews and fully involved them in discharge planning.

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Good

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

Bed management

Patients at the hospital paid for their care and treatment from their own funds or through private health insurance. The average length of stay on the acute wards was 17.5 days.

Patients only moved between different acute wards at the hospital when there was a clinical reason. For example, if they needed to move from a mixed sex ward to a single sex ward.

It was unusual for a patient to require a transfer to a psychiatric intensive care unit. Staff told us that recently a patient had been transferred to a psychiatric intensive care unit in a timely way.

Discharge and transfers of care

Psychiatrists spoke with patients about their recovery and their expected length of stay. All but one of the patients in the service were informal and understood their right to leave the service at any time.

Staff arranged appropriate follow up in the community. For example, in some cases, nursing staff and the patient's psychiatrist liaised with the patient's local community mental health team to ensure continuity of care. Staff escorted patients to the general hospital if this was necessary.

Facilities that promote comfort, dignity and privacy

At the previous inspection in January 2018, we said the provider must ensure that an appropriate level of planning and risk assessment takes place when a ward moved location. At this inspection, we confirmed that the provider had made the required improvement. For example, prior to this inspection, Ward 1A was temporarily closed for refurbishment. Staff said that the provider had created a 'ward opening and closing' checklist, which they completed. This included checking all equipment, bedrooms and ligature works completion before re-opening the ward.

The design, layout, and furnishings of the service supported patients' treatment, privacy and dignity. All patients using the service had their own bedroom and bathroom. Patients could ask staff to lock their bedrooms but in practice chose to leave them unlocked. Patients said they felt their possessions were safe and there were no concerns about loss or theft. They said they found the wards to be comfortable and well furnished.

Patients could access a gym and outside space. Patients could use a dining room and therapy rooms. Patients could access books and games whilst on the wards. Staff told us that patients on the second floor had asked for more access to table tennis and other games.

Most patients were satisfied with the quality and choice of food. Each ward had a kitchen which was always open so that patients could make drinks and snacks as they wished.

Patients could use their own mobile phone to make private calls.

Patients' engagement with the wider community

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the service and the wider community. Staff supported patients to maintain contact with their partners, families and carers.

Staff could support patients with religious needs, by facilitating access to places of worship and/or religious officials.

Patients could continue to attend therapy sessions once discharged from the hospital.

Meeting the needs of all people who use the service

The planning and delivery of care and treatment met patients' diverse needs. The service could accommodate patients with physical disabilities and mobility needs on the ground floor ward which was level access. Staff asked patients about their cultural and spiritual needs and could make plans for patients to have these met. For example, by arranging for spiritual leaders to visit the service.

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Good

Patients could choose food that met their individual requirements. Staff said that interpreters were seldom required but could be accessed when needed.

Staff were able to give examples of supporting patients who were LGBT+, in accordance with their preferences.

Listening to and learning from concerns and complaints

At our previous inspection in January 2018, we told the provider that they must improve their management of complaints. At this inspection, we found that there had been improvement and the provider now treated concerns and complaints appropriately, investigated them and learned lessons from the results.

We reviewed information about concerns and complaints that had been made about the acute wards from 1 November 2017 to 30 November 2018. The provider had recorded their response to each concern or complaint. Some complaints related to staff attitude and behaviour. In each case the provider had followed up with the staff members concerned to ensure that lessons were learnt. The hospital's quality manager collated information on lessons learnt from complaints and circulated information to charge nurses to pass on to ward staff.

At our last inspection in January 2018, not all complaint responses addressed all areas of complaint and a small number were not appropriately sympathetic. During this inspection, we reviewed a sample of five complaint files including in progress and closed cases. The responses were thorough and addressed all areas of complaint, the language was sympathetic and the provider apologised where necessary.

At our last inspection, complaint responses did not include information on the next steps to take if complainants were unsatisfied with the response. During the current inspection, complaint responses included contact details for the independent sector complaints adjudication service. Two complaints from 2018 went through the adjudication process and were partially upheld.

Patients told us they had information about how to make a complaint. The hospital aimed to acknowledge complaints within 48 hours and respond within 20 days.

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

Good

Leadership

The service had managers with the right skills, knowledge and experience to perform their roles. The nursing team on each ward was led by a charge nurse. The charge nurse provided 'hands on' care to patients as well as having a management role. They had all worked at the hospital for many years and had developed appropriate qualifications, skills and experience. However, they shared responsibility, so that there was no overall manager overseeing the wards. This had an impact on quality assurance and consistency on the wards, which the hospital director intended to address by introducing ward managers for each service.

Staff were positive about the charge nurses and said they created a supportive and effective ward team. Staff said senior staff visited the wards on occasion and spoke with patients.

At the time of the inspection, the provider was in the process of recruiting to a new post of ward manager who would provide leadership and consistency for all the acute wards.

Vision and strategy

Staff understood the provider's vision and values and how to put them into practice. The provider displayed their values for staff and patients to see. These were compassion, respect, commitment, recognition, and one team. We saw evidence of the values being applied. For example, patients told us that staff respected them and treated them kindly.

At the previous inspection in January 2018, we found that the provider's senior leadership team had more work to do to successfully communicate values to the frontline staff, and ensure consistency. At that time staff did not have the opportunity to contribute to discussions about the future of the service, for example, in relation to bed numbers.

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

Good

The hospital director, had recently introduced the role of staff and patient representatives, to promote more staff and patient input into the running of the hospital, and ensure that the hospital worked together as one team.

Culture

Most staff felt respected, supported and valued. Staff said the new hospital director had made some positive changes in terms of environmental improvements and promoting team building. For example, staff on one ward were due to go on an away day for team building. Some staff said they felt that the nursing staff did not always have sufficient recognition, although this was beginning to change under the new hospital director. Staff were hopeful that the appointment of ward managers would lead to improvements and better communication in the running of the wards.

Staff were aware of whistleblowing procedures and said they would feel able to raise any concerns without fear of retribution.

Therapy and nursing staff told us their immediate managers were very supportive. Staff told us team morale was high and they felt proud to work in the service.

Charge nurses and other senior staff reviewed staff performance through supervision, appraisals and audits. Charge nurses were confident that the provider would support them to deal with any staff competency issues. No staff reported bullying or harassment.

The hospital director had joined together what had previously been separate Christmas parties for medical staff and others, into one party to emphasise parity of esteem for all staff. He had also introduced awards for unsung heroes amongst the staff team, including non-clinical staff.

Governance

At our previous inspection in January 2018, we told the provider they must ensure that there were robust governance and quality assurance processes in place to identify areas for improvement in a timely manner. We also said that they must ensure that staff team meetings were held on a regular basis and include standard agenda items related to quality and safety.

At this inspection, we found that improvements had been made. Governance and quality assurance processes were more robust. The provider now had a governance framework, which reviewed risks and promoted quality and performance. Staff team meetings had taken place regularly. The agendas and minutes of these meetings included information on safety incidents and the lessons learned.

We read information on the outcome of care and treatment record audits that had been sent to the teams. These comprised details of missing entries on the care and treatment notes. Although we found evidence that a number of other relevant audits were undertaken by staff on a regular basis. Staff on the ward were not able to access the results of recent audits during the inspection or action plans as a result. There was therefore a disconnect between staff undertaking audits, with no clear evidence of changes made as a result.

Staff recruitment had been undertaken to fill the vacant posts of patient services manager, human resources manager, and a new post of facilities manager was being recruited to. The hospital director had produced a structured estates plan for the hospital, providing clarity over funds available, to prioritise areas appropriately.

Incident reporting and risk management processes were effective. The management team and ward charge nurses met each morning to review incidents, evaluate emerging risks, plan admissions and to make plans to ensure that patients and staff were safe. Admissions to the service were well planned with clear goals and plans for discharge. There was good communication between, nursing staff, medical staff and therapy staff. Charge nurses across the service were meeting monthly to review audits, complaints and lessons learned. The provider had started new forums for patients and staff to report their concerns in February 2019.

The hospital had an appropriate structure of committees to oversee the quality of care delivered including a health and safety committee. The quality performance management group was attended by the senior leadership team, lead consultants and sometimes by representatives from the French provider organisation. This provided an opportunity to discuss a range of relevant topics.

The hospital director planned to arrange for more staff inclusion in clinical governance meetings, including inviting teams to make presentations at these meetings.

Management of risk, issues and performance

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Good

Charge nurses were aware of the key risks on their wards and these were reflected in the trust's risk register. Risks recorded included risks in relation to the recruitment and retention of registered nurses and delays in relation to planned building works to improve the wards.

A number of improvements had been made to the ward environment, including provision of more anti-ligature fittings in bedrooms and en-suite bathrooms, locked charging towers for patients' mobile phones, and convex mirrors to address blind spots. Closed circuit TV was being installed in communal areas at the time of the inspection.

Senior management had made the decision to introduce controlled access to the hospital wards, in order to improve safety for patients.

The provider had a system for monitoring consultant psychiatrists' practising privileges at the hospital. The system included detailed information of all required checks undertaken, and when they were due to be renewed. However, at the time of the inspection, the information indicated that six of 69 consultants had not provided evidence of their renewed General Medical Council registration, and 17 had not provided evidence that they had up to date medical indemnity insurance. We discussed this with the hospital director, who provided assurance that consultants without this information were not able to see patients at the hospital. However, he acknowledged that there was some room for improvement to ensure that the system flagged any consultant who did not have all required checks in place, and undertook to address this.

Following the inspection the hospital director provided evidence that a new monthly review had been added to clarify whether the hospital would suspend or revoke any consultant's privileges. Following this a new updated list would be sent to the patient services and senior management teams.

Information management

The provider collected appropriate information, which included data on staffing, the patient experience, compliance with mandatory training and incidents. Charge nurses received data on incidents, which had occurred and lessons learnt.

Information governance systems included confidentiality of patient records. However, the use of both paper and electronic patient records resulted in some unnecessary duplication, which impacted on the time staff had to spend with patients.

We found that charge nurses still had some limitations on information to support them with their management role. For example, they did not have access to audits to reflect the performance of the service, staffing and patient care and identify gaps and improvements.

The provider recognised when incidents needed to be reported to external bodies, including the CQC. Since the previous inspection, the provider was providing more detailed information about incidents and actions taken as a result.

Engagement

Patients were asked to complete a patient satisfaction survey and the results were collated for 2018. The survey results showed patients were positive about the treatment they received from nurses, doctors and therapists. In addition, there were comment boxes in each ward.

A patient management forum meeting was held at the beginning of February 2019 with patient representatives and senior management. Issues raised included night staff conduct, water pressure in the showers and heating, and a request for art therapy at weekends. There was an action plan to address each issue raised.

A staff survey had taken place in December 2018 to January 2019. This showed that overall there has been a decline in the positivity of the response of the staff, although the majority of answers remained positive. Areas of concern raised included levels of pay, internal communication, work with bank staff and annual leave arrangements for therapists. Suggestions included more use of the intranet, and possible upgrading of the hospital's computer systems.

The first staff representatives meeting was held in the week before the inspection, and it was planned that staff would have an inbox to send suggestions for improvements at the hospital. Meetings were scheduled to be held monthly.

The hospital director advised that senior management would work closely with staff representatives to address staff concerns. Changes being considered included possible relocation of the staff room closer to the wards, reviewing pay and benefits. He was also introducing a new

team building budget for all teams. He planned to arrange for more staff inclusion in clinical governance meetings, including inviting teams to make presentations at these meetings.

Patients and carers had access to up-to-date information about the work of the provider and the services they used. For example, through the provider website.

Staff had access to the hospital's intranet, which held policies and documents relevant to their wards. This had been updated with more relevant information since the previous inspection including up to date guidance on working with patients who have eating disorders or substance misuse issues.

Learning, continuous improvement and innovation

Since the last inspection, the provider has purchased an online training system for registered nurses so that they could enhance their nursing skills. The provider told us that they were committed to obtaining AIMS accreditation (a recognised standard for acute wards, assessed by the Royal College of Psychiatrists) but had not started this process yet. The service was also due to introduce a new system for capturing patient feedback, and for virtual ward rounds with some consultants. They were looking into the possibility of providing electronic tablets to record patient monitoring in place of paper records.

Therapy staff told us that they could develop new care and treatment options for patients. They said the therapy programme was continuously reviewed and updated in response to best evidence of effectiveness and feedback from patients.

Good

Specialist eating disorder services

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

Are specialist eating disorder services safe?

Good

Safe and clean environment

Safety of the ward layout

The ward layout made it difficult for staff to observe all areas due to blind spots. These risks were mitigated by individual risk assessments through observations, which were assessed individually by staff. Observations ranged between constant one to one observations and hourly observations. The eating disorder ward was in a separate building from the rest of the hospital and was locked.

At the last inspection in January 2018, we found that staff did not have access to ligature risk assessments on the ward and staff were not clear on the location of the ligature risk assessments on the ward. On this inspection, we found staff had improved in this area. The ligature risk assessments were attached to the observation sheet. Staff also told us about the multiple ligature points on the ward and could tell us how they were being addressed for example ligature anchor points were identified in the form of taps on sinks, and the bathroom doors. An action plan was put in place following the ligature risk assessment in May 2018, to refit all the bathroom doors and taps to ensure they were anti-ligature. This work was completed in December 2018. Ligature awareness was also added as a topic in mandatory training. Staff were able to tell us about the location of ligature risks on the ward and how they would minimise the risks for patients. Ligature anchor points were noted on the checklist which staff used each hour.

The ward complied with guidance on same-sex accommodation. The ward was set over three floors. The second floor could be used as a male ward but was not in use at the time of the inspection. All bedrooms had en-suite facilities so patients could use bathroom facilities in private. Staff arranged for patients to have access to single-sex communal lounge areas on the ward.

At the inspection in January 2018, we found that staff did not have access to alarms to summon assistance. At the current inspection, staff had easy access to personal alarms and patients had access to nurse call systems which were located in patient bedrooms in an accessible position. Staff told us that they felt safer following the provision of personal alarms.

An external specialist provider completed a fire safety assessment for the hospital in October 2018, and we found evidence that all actions identified had been completed. At the previous inspection in January 2018, we observed that patients had placed towels over a number of bedroom doors to minimise disturbance during nightly observations, which would compromise safety in the event of a fire. It was not possible to check on this during the current inspection, as no patients were sleeping on the ward. However, the provider advised that one reason for the use of towels was to prevent doors slamming when it was windy. To address this, they had undertaken work to improve the sealing of windows.

Maintenance, cleanliness and infection control

All ward areas were clean and appropriately furnished and were well-maintained.

At the last inspection in January 2018, we were unable to find a cleaning task list, to evidence that all areas of the ward were cleaned regularly. On this occasion we saw recent cleaning records indicating that cleaning tasks were documented appropriately. Patient bedrooms, the communal living room and nursing office were visibly clean. In the community meeting, patients requested an improvement in the furnishings in the communal areas, to make these more adult friendly (as the unit had previously been used as a ward for adolescents).

At the last inspection in January 2018, we found that the wards had mattresses, which were mostly fabric-covered and not designed to be easy clean which reduced the effectiveness of infection control measures. During this inspection we found that staff were using impermeable covers to protect the mattresses. However, there were no audits available to show that the mattresses were being checked on a regular basis. Staff told us that soft furnishings were steam cleaned, but there were no records of when this took place. We noted that some of the sofas in the patients' lounge were stained.

At the last inspection in January 2018, there was no record of a recent infection control audit available. On this inspection staff had access to the most recent infection control audit from June 2018 via the hospital intranet.

Records showed that staff completed environmental checks on a weekly basis. Items highlighted in recent weeks included corridor lights needing replacement, and an issue with lights in the lift. Once recorded staff ensured that these were addressed swiftly.

Results from the hospital-wide patient survey for 2018, indicated 85% satisfaction with cleanliness.

At the previous inspection in January 2018 we found that staff did not record the temperatures of the two refrigerators in the kitchen, to ensure food was kept at the correct temperature, and there was one item of outdated food stored. At the current inspection, we found that there was a system in place to monitor refrigerator temperatures, and staff checked the expiry of foods stored on a regular basis.

Disposable gloves, aprons and liquid hand gel were available for staff to use when preparing breakfast and snacks for patients.

Clinic room and equipment

At the previous inspection in January 2018, we found that not all medicines were stored securely and some medical devices were not monitored and maintained appropriately. At the current inspection, we found that clinic rooms were fully equipped with accessible resuscitation equipment and appropriate emergency drugs that staff checked regularly. However, we found issues in the frequency of checking of some equipment. For example, there were some gaps in the weekly clinic room checks. Staff told us this was due to the ward not being in use at the time. We were unable to find a template for the defibrillator daily checks. Staff had put this in place by the second day of inspection. There were also some gaps in how often staff checked the calibration of the blood glucose machine.

There was an oxygen cylinder for use in an emergency. However, the clinic room did not have a warning sign on the door in respect of this being highly flammable. Once we brought this to the attention of senior management, we found that this had been put into place on the second day of inspection.

The clinic room was locked and not accessible to patients. Although all medicines were stored in locked cupboards, the key for the medicines fridge was left in the lock during the inspection. Staff recorded the minimum and maximum temperature of the fridge and the clinic room, on a daily basis to ensure they remained in the appropriate range.

Staff had recorded the date of assembly of the sharps bin in the clinic room for the safe disposal of used needles and other sharp items as appropriate.

Safe Staffing

Nursing staff

Managers had calculated the number and grade of registered and non-registered nurses required. Two registered nurses worked each day. Staff were supported with a third registered or non-registered nurse depending on the number of day patients on the ward. At the time of the inspection, due to the ward having only one inpatient, the night staff consisted of one eating disorder nurse who would work on the general psychiatric ward where the patient moved to each night.

There were two charge nurses employed on the ward. Charge nurses could adjust staffing levels daily to take account of the case mix and patient needs.

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. Between 1 September 2018 and 30 November 2018, the bank and agency usage included 45 shifts filled by bank staff and 31 filled by agency staff to cover sickness, absence or vacancies. The provider completed a review of agency staff usage at the hospital which highlighted a need for the hospital to recruit more non-registered nurses. There was a recruitment drive underway to address this. However, there were no staff vacancies on the eating disorder unit.

At the previous inspection in January 2018 we found that there were some gaps in recruitment checks for staff. At the current inspection we observed that the hospital used a recruitment tracker, to ensure that all appropriate checks, including two written references, and disclosure and barring checks, were in place prior to new staff commencing work.

When agency and bank nursing staff were used, they received an induction and were introduced to the ward. Bank staff had access to the hospital mandatory training along with supervision. Agency staff were inducted using a checklist.

Between 1 December 2017 and 30 November 2018, the provider reported a sickness rate for the eating disorder ward of 7% and a turnover of two out of 13 staff on the eating disorder ward.

Staffing levels allowed patients to have regular one-to-one time with their named nurse and these meetings were recorded clearly in patients' notes.

Medical staff

The provider had 55 consultants with practising privileges. The hospital carried out a range of checks to ensure that each doctor was fit to carry out their role. These checks included General Medical Council registration, revalidation, appraisal, Section 12 approval, Disclosure and Barring Service, medical indemnity and the completion of a signed agreement with the hospital.

On the eating disorder ward, there was currently one psychiatrist who accepted referrals and screened admissions. They were the responsible clinician for all patients on the ward.

The full-time consultant was easily contactable when not on the ward. A junior doctor was also available on the ward.

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Mandatory training

Staff had received and were up to date with appropriate mandatory training.

The completion rate of mandatory training for staff within the hospital was 81%. The training included adult and child safeguarding, basic life support, managing violence and aggression and nasogastric tube feeding training.

Bank staff were also able to access mandatory training. Managing violence and aggression and life support training were delivered face to face, with the rest of the mandatory training provided online.

Human resources produced a quarterly mandatory training report for the ward each month to ensure that staff addressed any gaps.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff recorded a risk assessment of every patient on admission and updated it regularly. However, some admission forms were not completed as required, for example ticks were used instead of dates (where dates were required) on the admission checklist.

Staff were aware of and dealt with any specific risk issues, such as an increased vulnerability to pressure ulcers for patients with very low body weights.

Staff identified and responded to changing risks to, or posed by patients. A daily risk assessment and rating was completed by both staff and the patients, each completing different parts of the form.

Management of patient risk

Staff completed risk assessments which fed through to relevant risk management plans. Risk management plans included body maps, which assessed patients' skin integrity and risks of pressure ulcers, and a mitigation plan.

Staff followed the provider's policies and procedures for use of observation including to minimise the risk from potential ligature points. All patients would begin on 15-minute observations on admission and this would be

reviewed if the risks increased or decreased. Rooms that were not in use, including the laundry room or activities room, were kept locked. There was no process in place for reviewing these blanket restrictions.

Informal patients could leave at will and told us that they knew this. The ward displayed signs explaining the rights of informal patients.

If the top floor of the ward was in use, a staff member was stationed there, to ensure on patients' safety in this area.

Use of restrictive interventions

Staff had not used restraint or rapid tranquilisation on this ward in the 12 months leading up to the inspection.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate.

Staff followed safe procedures for children visiting the ward. A policy was in place regarding children visiting the ward. Anyone under the age of 18 was always accompanied by an adult when on the ward.

Staff understood multi-agency procedures to protect patients from abuse and the service worked well with other agencies to do so. The hospital had a lead for adult and children's safeguarding. Staff said the lead was readily available for advice and support.

Patients said that the wards had a safe, calm atmosphere and they were certain that staff would act to prevent any bullying or harassment.

Staff access to essential information

Staff used a combination of both electronic patient records and paper records to record patient information. This did not cause staff any difficulty in entering or accessing information.

All information needed to deliver patient care was available to relevant staff including agency staff when they needed it and was in an accessible form. This included when patients moved between wards.

Medicines management

Staff followed good practice in medicines management in transport, storage, dispensing, administration, medicines reconciliation, recording, disposal and did this in line with national guidance.

Staff nurses would dispense medicines on the ward, wearing a tabard to indicate that they should not be disturbed. There were no nurse prescribers on the ward, and staff did not give covert medicines.

The pharmacist would complete medicines checks on the ward at least weekly, and ensure medicines were stocked and in date. Patients were able to meet with the pharmacist each week to discuss their medicines. Patients also had access to leaflets regarding their medicines.

Staff would review patients' medicines and discuss this with each patient in ward round, including monitoring any impact on their physical health, and in line with national guidance for patient with an eating disorder. Nurses would also discuss medicines with patients during administration, and remind them why they were prescribed specific medicines, when necessary.

There were 10 medicines errors between 1 June 2018 and 30 November 2018 throughout the hospital. The provider did not report on this per ward. When a medicines error occurred, staff told us they would report this as an incident. There was also a procedure in place in the event of any errors in dispensing medicines. Doctors would take necessary steps and inform the patient involved if such an error occurred.

Pharmacists carried out weekly audits of prescription charts on the ward, and monthly medicines audits for the hospital.

Track record on safety

In the last 12 months, there was one serious incident reported on the ward. This was with regards to a minor admitted to the adult ward as there was no other bed available at other eating disorder services.

Reporting incidents and learning from when things go wrong

At the previous inspection in January 2018 we found that staff were not always aware of learning from incidents in the hospital. At the current inspection we found that this had improved.

All staff knew what incidents to report and how to report them. Staff could give examples of incidents reported and

Good

Specialist eating disorder services

learning from incidents. For example, staff told us about faster escalation procedures after a self-harm incident. The nurse in charge was able to increase the frequency of nursing observations to ensure the safety of patients.

The hospital compliance manager analysed the incidents and emailed these to the charge nurses on the ward. This would include learning from incidents including outcomes and areas for improvements. This report was discussed at the monthly quality performance management group.

The monthly meetings had a set agenda which included incidents but was recorded as nil each time as this only related to the eating disorder unit. It was therefore not clear if the lessons learned from incidents across the hospital were discussed. However, staff we spoke with could tell us about incidents across other units.

Learning from incidents that staff told us about included; changes to the hospital's search policy making it more rigorous; search training for staff; protocols for ensuring faster escalation if patients were not engaging with staff; nurses being given the authority to increase observations; and rotating observations amongst staff so that staff are not observing the same patient for prolonged periods of time.

Incidents were reported by the nurse and doctor on a dedicated electronic form and sent to the compliance manager. These were also discussed in morning meetings with senior staff, and at daily ward handovers. We also saw evidence that learning from incidents was discussed at individual staff supervision meetings.

Senior staff would investigate serious incidents and discuss these at the monthly steering group. A monthly analysis was prepared and shared with each ward. Any lessons learned were published weekly and displayed on staff notice boards, and also available to all staff on the hospital intranet system.

Staff had access to a duty of candour policy on the intranet, to ensure transparency about any errors in patients' treatment. Staff we spoke with were aware of their duties in this area.

Staff were debriefed and received support after a serious incident. Debriefs were completed by the staff member allocated responsibility.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff completed a comprehensive mental health and physical health assessment of each patient in a timely manner at, or soon after, admission, and records confirmed this.

Staff worked with inpatients to create plans for care that related to the needs identified at assessment. They completed these from the day of admission and updated them regularly. They included clear details of patients' views and wishes and how these were taken into account.

Patients confirmed that their care plans were individualised and staff followed these plans on the ward. For example, taking into account their wish not to see their weight, and in determining the length of post-meal support that they needed.

However, we looked at the care records of three day-patients, and found that they did not have up to date care plans and risk assessments in place, to show that their needs were being reviewed regularly.

Staff assessed and monitored physical health needs arising from the eating disorders, such as tachycardia, regularly checking bloods and vital signs and urinary symptoms. They also provided support with wider physical health needs. For example, arranging dental care for a patient, with support to attend appointments at a local clinic.

Records showed staff assessed patients for the risk of refeeding syndrome, which can include cardiac, pulmonary and neurological symptoms. When required they carried out appropriate monitoring and treatment. For example, prescribing appropriate meal plans and thiamine, taking regular bloods and keeping the patient in a warm and restful environment.

The provider undertook regular audits of clinical notes, at least quarterly. We saw care notes audits from October 2018, January and February 2019. It was not always clear

from the records of audits what actions were taken as a result. However, management advised that they relayed any individual areas for improvement to the charge nurses, to ensure that they were addressed.

Best practice in treatment and care

Staff were aware of national guidance for the treatment of adults with an eating disorder. For example, the National Institute for Health and Care Excellence (NICE) recommended treatments, such as individual eating disorder focussed cognitive behavioural therapy and access to psychoeducation groups about a specific diagnosis. The service offered these, as well as a family forum, and a range of therapies including family therapy, art therapy, mentalisation, and mindfulness.

Since the previous inspection, we found that staff had much easier access to NICE and other guidance such as the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) on the provider's intranet, so they could refer to them.

There was no MARSIPAN group set up to link the provider and NHS and/or other private hospitals, or to act as a formal pathway for the management of physical health complications of anorexia nervosa. Instead informal pathways and case by case referrals were relied upon.

The service was a member of the Royal College of Nursing specialist interest group in Eating Disorders, and engaged in research with the Maudsley.

The service employed a clinical psychologist, occupational therapist and dietitian, and a range of psychotherapists, as part of the multidisciplinary team, as recommended for this patient group.

The dietitian assessed nutritional status, prescribed individualised eating plans, and supported behaviour changes around food. On admission, the dietitian met with the patient for an individual assessment. They also invited family members to the assessment, if the patient consented, and took account of their views.

The service offered three stages of meal time support, which meant they could meet the needs of a range of patients. Intensive support involved one-to-one meal support in the ward dining room. The next stage was eating together in a small group in the ward dining room. The final stage was eating as a group in the main hospital restaurant.

Patients eating in the restaurant would either have their meals portioned by staff, or could self-portion, depending on their care plan, which was reviewed in weekly ward rounds.

The occupational therapist offered group work and supported patients in eating out, creative groups and goal setting. There was a kitchen they could use with patients to support the preparation of meals, as part of treatment. Each patient was automatically referred to the occupational therapist during their admission.

Staff referred to a meal guideline document, which outlined five meal plans, pre-designed to meet the needs of different patients. This included plans for full weight gain through to a plan for patients at high risk of refeeding syndrome. These meal guidelines were detailed and reflected national guidance. Staff had an understanding of the risks and management of refeeding syndrome.

Nursing staff used documented guidelines written by the dietitian that outlined the exact proportions of food to prepare at breakfast and snack times. This included details of how much food supplement to provide if a patient was unable to finish elements of their meal.

There was a weekly timetable available to both day and inpatients which included individual and group therapy and psychoeducation groups. This was put together by the lead therapist, who was a clinical psychologist. The wider therapy team met once a month to review the timetable and make any changes to meet the needs of the patient group at the time.

The ward had fast acting carbohydrate gels available on the ward for emergencies.

Oral refeeding was the preferred method on the ward. There was a policy in place for the use nasogastric feeding. However, no patients had been naso-gastrically fed (by tube) on the ward in the last 12 months.

Records showed that staff completed outcome measures regularly during patient admissions in order to capture data on severity of illness over time. Tools used included Beck's Depression Inventory, Health of The Nation Outcome Scales (HoNOS) and the Eating Disorder Examination Questionnaire. This meant staff could demonstrate changes over the time of admission, but they were not always using the tools to their full potential in monitoring patients progress whist admitted.

Although staff participated in regular clinical audits, they did not have access to the results of recent audits. This meant that staff could not always identify areas of good practice and areas of improvement and put action plans in place to address them.

Skilled staff to deliver care

The team included, or had access to, the full range of specialists required to meet the needs of the patient group. This included nurses, doctors with specialist knowledge of eating disorders, an occupational therapist, clinical psychologist and a dietitian.

At the previous inspection in January 2018, we found that staff who worked on the ward were not provided with sufficient training in their roles to support patients with eating disorders. During the current inspection, we found that staff displayed a knowledge and understanding of providing treatment to patients with an eating disorder. They had been provided with training sessions in topics relevant to working with this client group. However, there was no formal core competency framework in place to ensure that staff had the necessary knowledge and skills.

Staff told us that they kept up to date with training on naso-gastric feeding at least annually, and had the opportunity to attend specialist conferences about eating disorders. Charge nurses were undertaking training to be able to train other staff in naso-gastric feeding, should this be necessary. All nursing staff across the hospital undertook new training in the last year on searching patients on returning to the hospital from leave. Staff had not undertaken any training in working with patients with autism, although patients with autism have a higher propensity to develop eating disorders.

All new hospital staff received an induction to the hospital from the human resources department. This included hospital policies, procedures, information on staff specific roles and responsibilities. A local induction then took place on the ward. Although staff said that new staff read detailed information about protocols on the eating disorder ward, there was no record kept to evidence that they had read and understood this information.

Supervision compliance for staff on the ward was variable, recorded as 86% in January 2019 and 50% in February 2019 (when there was very low occupancy on the ward). However, staff told us that they received regular monthly supervision and felt supported. We looked at four records of supervision for the ward, which indicated that a wide range of topics were routinely discussed including lessons learned from recent incidents or complaints.

Therapy staff received regular supervision from senior staff of the same discipline, in line with professional requirements. Junior doctors received supervision from the consultant in addition to the supervision provided by the agency that employed them. Junior doctors did not receive any formal training in eating disorders, but the consultant psychiatrist advised that she worked closely with them when they first came to work on the ward.

Team meetings took place on the ward, but staff did not use a set agenda, and topics did not include feedback on any recent complaints, incidents or staff training needs.

At the last two inspections of the hospital in January 2018 and February 2017, we identified that the provider needed to ensure nursing staff received regular appraisal. The provider had reviewed the appraisal process, and introduced a new recording format, to improve the quality of appraisal. Prior to the inspection 77% of staff had had an appraisal within the last year, with others due to complete their appraisals by the end of March 2019.

Managers had systems in place to address poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings where they discussed each patient, their care needs and recovery. The psychiatrist, therapy staff and nurses attended. Patients were invited to weekly ward round meetings with the multidisciplinary team, and involved in making decisions about their care. Staff had a clear understanding of the importance of the contribution from each different discipline to patient care.

Staff shared information about patients at handover meetings within the team. This was done twice a day between nursing shifts. Staff kept up to date and detailed records of patient needs and could refer to these notes throughout their shift.

The full multidisciplinary team had been involved in providing a training day, for staff covering refeeding syndrome, dangers of eating disorders, bloods and monitoring, portion sizes, and family dynamics.

Good

Specialist eating disorder services

The nursing team attended ward meetings every two weeks, or more frequently if the ward was unsettled.

Staff did not routinely work with external agencies when providing care to patients.

Adherence to the MHA and the MHA Code of Practice

Staff received mandatory training in the Mental Health Act 1983 (MHA), with overall training compliance for the hospital at 81%. The provider had relevant policies and procedures that staff could access.

The Mental Health Act administrator was based on site at the hospital. An audit of MHA processes undertaken in December 2018 indicated that improvements could be made in the use of the Section 5(2) holding power, to ensure that this was only used strictly in accordance with the law, with recommendations made to address this.

Low numbers of patients were detained under the MHA each year. At the time of the inspection there were no detained patients on the ward.

Patients had access to information about independent mental health advocacy, which was on a noticeboard on the ward as well as in the information pack provided to new patients.

At the previous inspection in January 2018, we found that staff did not make it clear enough to patients about their right to leave the ward if they were not formally detained under the MHA. During the current inspection there was a notice by the front door to the unit, informing informal patients of their right to leave at any time. Informal patients we spoke with were clear about their right to leave the unit.

Good practice in applying the MCA

Staff received mandatory training in the Mental Capacity Act, with figures for the hospital indicating 81% compliance in this area at the time of the inspection.

There were no deprivation of liberty safeguards applications submitted by this ward in the last 12 months.

On admission, staff assessed patients' capacity to consent to treatment, either for the general care package or for specific interventions, such as nasogastric feeding. Staff re-assessed capacity for new decisions or if there was a change in the patient's situation.

We looked at four patients' care records during the inspection, and found that one of these did not include a review of mental capacity one month after admission.

Staff audited the mental capacity assessment records as part of the care records audits for the hospital. In February 2019, an audit of 12 clinical notes indicated that decision specific mental capacity assessments were recorded on 83% of records. An action plan was due to be put in place to address gaps in recording.

Are specialist eating disorder services caring?

Good

Kindness, dignity, respect and support

Patients told us that staff treated them well and behaved appropriately towards them. They said that staff were good at getting to know them, and communicating about any delays or changes to the programme. They said staff had a good understanding of their needs and could identify when they might need extra support. They said that they felt safe and secure at the unit.

Staff were discreet, respectful and responsive, supporting patients with help, emotional support and advice as they needed it.

Staff supported patients to understand and manage their care, treatment or condition, through one-to-one support and group therapies. Care plans showed staff supported patients to talk to staff about their illness and patients reported post-meal supervision was helpful.

Patients knew who their key nurse was, and what support they could offer. They told us that they felt comfortable approaching them at any time, although staff were often busy.

Discussion with staff and review of patient records showed staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Patients confirmed that they were treated as a 'whole person,' with staff going above and beyond to support them with their individual needs.

Staff kept information about patients confidential. Since the previous inspection, the hospital had introduced

privacy screens on computers, so that they could not be overseen from a distance. There was no patient information on display in the nursing offices or elsewhere on the ward. Staff had private spaces where they could discuss patient care without being overheard. Patients said they felt confident staff kept information in line with confidentiality requirements.

One patient told us that they would like to have a kitchen where they could serve themselves on the unit, instead of going to the hospital restaurant. We undertook the walk to the dining room, which was carried out twice daily by patients from the eating disorder unit who were well enough to have meals in the main hospital restaurant. Apart from having to cross a small road, this involved entering the hospital through two alarmed doors, which sounded loudly on entry, until they were switched off, and then walking past the smoking room for the hospital. We fed back to hospital management that this was not a very pleasant experience, and they undertook to review options for accessing the restaurant, following consultation with patients.

The involvement of people in the care they receive

Involvement of patients

Patients said staff worked with them to develop care plans and risk management plans, and made fair decisions based on their risks. They said that they were able to discuss their medicines regularly with nurses, doctors and the pharmacist.

Records showed staff involved patients in care planning and risk assessment, with sections completed by each of them.

On arrival at the ward, staff gave patients an information pack including what they should expect, introduction to the team, a timetable of groups, and how to complain. One patient told us that although they were on the eating disorders programme staff had opened up other therapy groups to them, tailored to what they needed.

One patient told us that staff had helped them to get a part-time job, as part of their recovery.

The new hospital director had recently introduced the role of patient representatives for the hospital, to feedback to the senior management team. One patient from the eating disorder unit had undertaken this role. Patients told us that they could influence the programme, and make changes within the hospital through the patient and management forum.

Staff supported patients to give feedback on the service they received. Patients could give verbal feedback at weekly community meetings. These meetings were recorded and minutes showed that staff acted on feedback. Patients told us that staff recorded feedback and took action.

There was a suggestions box available for anonymous written feedback in the lounge. However, staff said that this was rarely used.

The provider collected patient feedback surveys across the whole hospital every month and made results available to staff on the intranet. The hospital-wide results for 2018 indicated 92% satisfaction with dignity and respect, 95% satisfaction with nursing staff, 90% satisfaction with therapists, 91% with consultants, 93% with ward doctors, and 87% with addressing the issues that brought them to hospital.

There was information on the ward about the availability of a patient advocate. An advocate is someone independent of the hospital who can support a patient to understand their rights, help them raise concerns and assist them to become involved in their own care. Patients were aware of the advocate's role and knew how to access them.

Group therapies offered patients education and information on the nature, course and treatment of eating disorders. Staff and patients could discuss information, harm minimisation and short and long-term risks associated with an eating disorder. Patients learned about risks such as damage to teeth, the reproductive system, osteoporosis, growth and development.

Staff told patients what level of observation they were under and discussed how it was carried out and the review process for it. The patients we spoke with were aware of the level of observation they were on.

Involvement of families and carers

Records showed the patients' main family/carers were identified and contact details were recorded with the consent of patients.

Good

Specialist eating disorder services

Staff informed and involved families and carers appropriately and in line with patient wishes. Patients told us and records confirmed that staff supported patients to maintain relationships outside of the hospital. For example, with family members, friends and partners.

Staff provided families and carers with support when needed. The service ran a fortnightly carers support group that all family and carers could attend. This ran over eight sessions, based on the Maudsley family method, and offered education and information on the nature, course and treatment of eating disorders. The content included practical skills for managing distress, dealing with challenging behaviours, moving towards recovery, managing food, and how to be an effective carer.

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

(for example, to feedback?)

Good

Access and discharge

Bed management

Patients were referred to the ward by clinicians from external services, GPs, or through self-referral. Patients were offered the opportunity to visit the ward before admission. The admissions pathway document stated that an admission had to be agreed by both the admitting doctor and the patient for it to take place. At the start of an admission, staff and patients discussed the length of stay and therapeutic package to be delivered; this was usually influenced by funding arrangements and patients were made aware of any limitations. In the last year, patients used the service for periods between one month to one year, with an average stay of 23 days. The ward occupancy for this period was 45%.

Patients could be admitted as inpatients or day patients, depending on their level of need. Day patients attended the service between 8am and 7pm each day and took part in all meals, therapeutic groups and sessions. From the start of treatment, staff said there was a clear discussion and agreement with patients about their goals for treatment, including, when appropriate, any weight restoration.

There were no written exclusion criteria for the ward recorded in policies or documents, but the admitting psychiatrist said that patients with a chronic physical illness or psychiatric risk would be carefully considered for their appropriateness. The final decision to admit was the responsibility of the admitting psychiatrist.

Staff considered the needs of the patient at each referral. If it was clear a patient required more intensive care or long-term care than the ward could provide, the reason for not accepting the referral was explained to the patient and/or the referrer. When it became clear a patient required more intensive care during their stay, staff liaised with external services to arrange a transfer.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. When patients were moved or discharged, this happened at an appropriate time of day.

Discharge and transfers of care

When appropriate, patients were offered the option of day care as a step down from inpatient care prior to discharge. Outpatient care was not offered by the service.

Where patients needed longer term care in another facility, staff liaised with external organisations, including NHS hospitals, to transfer patients.

Patients were aware of their discharge plans and able to speak with staff about these plans. Patient notes included brief information about discharge plans, but these did not focus on each patient's strengths, and there was a lack of detail about longer term plans for care after discharge.

The facilities promote recovery, comfort, dignity and confidentiality

Staff and patients had access to a range of rooms and equipment to support treatment and care. This included a lounge, a quiet room, a kitchen and dining room and therapy rooms. The clinic room was too small to hold an examination couch, so physical examinations took place in patient bedrooms.

At the previous inspection in January 2018, we found that patients did not always have free access to fresh air on a daily basis. There was no outside space that patients could access for fresh air without leaving the ward through the

front door, which had to be opened by staff. However, during the current inspection, patients told us that they were able to go out either alone, or with a staff escort, as often as they wanted to.

The service had an information pack that was provided to patients before admission. This contained helpful information about the care provided at the service and how to be involved in decisions. It also outlined ward facilities, mealtimes, weighing guidelines and how to access advocacy and give feedback about care.

Patients had their own bedrooms. These were well furnished, in good condition, had minimal ligature risks, and had en-suite facilities. Patients could personalise their bedrooms. Patients could store their possessions in their bedrooms and staff locked these rooms when the patient was off the ward.

Patients could have visitors on the ward or meet them on the main hospital site. There were small therapy rooms available that could be used, but patients were also able to meet visitors in their bedrooms if they wished. Visiting hours were between 7pm and 10pm each weekday night and between 9am and 10pm at weekends. This allowed patients to have a lot of time with their friends and family if they wished to and supported them in maintaining these relationships.

Patients could make a phone call in private. Patients kept their own mobile phones and accessed wi-fi on the ward.

Food was prepared freshly on site at the main hospital restaurant and set meal plans ensured patients' personal nutritional and fluid intake needs were met, with vitamin supplements where necessary. Meals were varied and reflected individual cultural and religious needs. When needed, food was delivered to the ward for patients who were on supported meals.

Ward staff provided post-meal and snack support to patients, appropriate to each patient's care plan.

Staff told us that they had requested a dishwasher for the ward, but this had not yet been received.

The ward weekly timetable was available for patients to see on the ward. This included daily meal times and a range of group therapies and educational sessions from Monday to Friday, and some weekend sessions. Groups included goal setting, social eating, communication, cooking, assertiveness and anger, body image, and meal planning. In addition, patients could use the art room, access the hospital gym, play board games, access wi-fi.

Patients' engagement with the wider community

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the service and the wider community. Staff supported patients to maintain contact with their partners, families and carers.

Staff could support patients with religious needs, by facilitating access to places of worship and/or religious officials.

One patient told us that staff had supported them in obtaining a part time job.

Meeting the needs of all people who use the service

The service was accessible for patients with mobility needs or those with very low weight who used a wheelchair. There was an assisted toilet next to the nursing office and a lift that staff and patients could use to reach all floors of the ward. If the service could not support a patient with a particular disability, they would explain to the referrer why this was the case. Air pump mattresses were available for patients at risk of pressure ulcers. Staff could access interpreters and/or sign language interpreters where necessary.

There was information available on the ward about general healthcare, local services, patients' rights and how to complain.

Staff members recorded and addressed patients using the name and title they preferred. Staff said they offered patients a staff member of the same gender and/or a chaperone of the same gender, for physical examinations.

Staff were able to give examples of supporting patients who were LGBT+, including a patient who identified as transgender, in line with their identified gender.

The ward ran a weekly group for patients to confirm and clarify any questions about the following week's meal plans. This was run in a structured way and allowed patients to be involved in the plan. Although this was not carried out on a day that the dietitian was on the ward, staff

and patients told us that this did not usually lead to any changes when the dietitian reviewed them. Patients told us that involvement in meal planning was helpful in their treatment.

Listening to and learning from concerns and complaints

Staff addressed and recorded verbal complaints raised by patients. It patients were unhappy with the response, staff encouraged them to make a formal complaint. The hospital aimed to acknowledge complaints within 48 hours and respond within 20 days.

At our last inspection in January 2018, not all complaint responses addressed all areas of complaint and a small number were not appropriately sympathetic. During this inspection, we reviewed a sample of five complaint files including in progress and closed cases. The responses were thorough and addressed all areas of complaint, the language was sympathetic and the provider apologised where necessary.

At our last inspection, complaint responses did not include information on the next steps to take if unsatisfied with the response. During the current inspection, complaint responses included contact details for the independent sector complaints adjudication service. Two complaints from 2018 went through the adjudication process and were partially upheld.

In the 12 months from December 2017 to November 2018 the hospital overall received 34 complaints, six of which were upheld, and one of which was referred to the ombudsman. Three related to the eating disorder ward.

Staff could give examples of complaints and discussed learning points in supervision and at team meetings.

Are specialist eating disorder services well-led?

Good

Leadership

Since the previous inspection a new hospital director was in post, who had made a number of changes to the governance of the service. He identified immediate challenges relating to the facilities and nurse leadership, and had introduced new posts to address these issues. These posts were a head of facilities, and ward manager positions.

The eating disorder ward did not have a ward manager and was led by a nurse in charge on each shift. There were three nurses who took on this role throughout the week. The nurses had different levels of experience in this role. The charge nurses reported to a nursing services manager.

The decision had been made to recruit a ward manager for the unit, and recruitment was taking place to fill this role at the time of the inspection. This step had been taken to address any inconsistencies in leadership and decision making across shifts and ensure clear lines of responsibility for all tasks.

Members of nursing staff, including the nurse in charge, were visible in the service and accessible to other staff and patients.

At the previous inspection in January 2018, we found that there had been insufficient planning and risk assessment prior to the relocation of the eating disorder ward to a different building. Since then, the provider had put in place a checklist of protocols for opening and closing wards.

Vision and strategy

The provider displayed their values for staff and patients to see. These were compassion, respect, commitment, recognition, and one team. We saw evidence of the values being applied. For example, staff treated people with dignity and respect and compassion, and worked together as a team.

At the previous inspection in January 2018, we found that the provider's senior leadership team had more work to do to successfully communicate values to the frontline staff, and ensure consistency. At that time staff did not have the opportunity to contribute to discussions about the future of the service, for example, in relation to bed numbers. The hospital director, had recently introduced the role of staff and patient representatives, to promote more staff and patient input into the running of the hospital.

Culture

Good

Specialist eating disorder services

At the previous inspection, we noted that there was not a culture of involving ward staff in making decisions or planning changes such as the relocation of the eating disorder ward.

Staff told us that the hospital director had made changes ensuring more say for staff and patients in the running of the hospital, in the form of staff and patient representative forums. Staff said that they felt more valued, and senior management including the hospital director, came to visit the ward. Staff had requested new furniture for the staff room, and a possible relocation for this room to be closer to the wards, and this was being considered by the senior management team.

The hospital director had joined together what had previously been separate Xmas parties for medical staff and others, into a joint party to emphasise parity of esteem for all staff. He had also introduced awards for unsung heroes amongst the staff team, including non-clinical staff.

Staff were positive and proud about working on the ward and in their team, and told us they had regular supervisions sessions, and appraisals. The hospital director advised that the introduction of ward manager posts at the hospital would provide staff with further opportunities for career development.

Senior staff dealt with poor staff performance when needed.

Governance

The hospital had an appropriate structure of committees to oversee the quality of care delivered. The quality performance management group was attended by the senior leadership team, lead consultants and sometimes by representatives from the French provider organisation. This provided an opportunity to discuss a range of relevant topics. Each month the senior clinical staff from the ward and senior hospital managers met at a steering group. This meeting was to discuss emerging trends on the ward, training requirements for the team and feedback from carers and patients. Senior and operational managers met weekly, and a charge nurse forum was held every month. The hospital director had introduced staff and patient representative roles, who met with the senior management team regularly. He had also expanded the range of staff attending quality improvement meetings to include a charge nurse, and advised that he planned for pharmacy to be represented also.

At the previous inspection in January 2018, we found that the structures in place did not ensure that key learning was shared effectively with the staff delivering care. We also found that the assurance processes were not yet ensuring that areas for improvement were identified and addressed in a timely manner. In response the provider had arranged for more audits to be undertaken, and was planning to produce a schedule of audits to be undertaken across the hospital.

Although we found evidence that a number of relevant audits were undertaken by staff on a regular basis. Staff on the ward were unable to access the results of recent audits during the inspection. There was therefore a disconnect between staff undertaking audits, with no clear evidence of changes made as a result.

The hospital director had introduced the role of ward manager for each service, in order to address consistency issues, identify and implement improvements, and improve communication between senior managers and ward staff. Recruitment had been undertaken to fill the vacant posts of patient services manager, human resources manager, and a new post of facilities manager was being recruited to.

The hospital director had produced a structured estates plan for the hospital, providing clarity over funds available, so that the management team could make proactive plans for future improvements.

Management of risk, issues and performance

Staff at ward level could escalate concerns when required through the monthly steering group.

A number of improvements had been made to the ward environment, including provision of more anti-ligature fittings in bedrooms and en-suite bathrooms, locked charging towers for patients' mobile phones, and convex windows to address blind spots. Closed circuit TV was being installed in communal areas at the time of the inspection.

Senior management had made the decision to introduce controlled access to the hospital wards, in order to improve safety for patients.

The provider had a system for monitoring consultant psychiatrists' practising privileges at the hospital. The system included detailed information of all required checks undertaken, and when they were due to be renewed.

However, at the time of the inspection, the information indicated that six of 69 consultants had not provided evidence of their renewed General Medical Council registration, and 17 had not provided evidence that they had up to date medical indemnity insurance. We discussed this with the hospital director, who provided assurance that consultants without this information were not able to see patients at the hospital. However, he acknowledged that there was some room for improvement to ensure that the system flagged any consultant who did not have all required checks in place, and undertook to address this.

Following the inspection, the hospital director provided evidence that a new monthly review had been added to clarify whether the hospital would suspend or revoke any consultant's privileges. Following this a new updated list would be sent to the patient services and senior management teams.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. For example, staff completed online incident forms that were collated monthly by a staff member off the ward.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well.

Information governance systems included protecting the confidentiality of patient records. However, the use of both paper and electronic patient records resulted in some unnecessary duplication, which impacted on the time staff had to spend with patients.

Charge nurses still had some limitations on information to support them with their management role. For example, they did not have access to audits or the action plans arising from audits reflecting the performance of the service, staffing and patient care.

The provider recognised when incidents needed to be reported to external bodies, including the CQC. Since the previous inspection, the provider was providing more detailed information about incidents and actions taken as a result.

Engagement

Patients were asked to complete a satisfaction survey and the results were collated for 2018. The survey results showed patients were positive about the treatment they received from nurses, doctors and therapists. In addition, there were comment boxes in each ward.

A patient management forum meeting was held at the beginning of February 2019. Issues raised included night staff conduct, water pressure in the showers and heating, and a request for art therapy at weekends. There was an action plan to address each issue raised.

A staff survey had taken place in December 2018 to January 2019. This showed that overall there has been a decline in the positivity of staff responses, although the majority of answers remained positive. Areas of concern raised included levels of pay, internal communication, work with bank staff and annual leave arrangements for therapists. Suggestions included more use of the intranet, and possible upgrading of the hospital's computer systems.

The first staff representatives meeting was held in the week before the inspection, and it was planned that staff would have an inbox to send suggestions for improvements at the hospital. Meetings were scheduled to be held monthly.

The hospital director advised that senior management would work closely with staff representatives to address staff concerns. Changes being considered included possible relocation of the staff room closer to the wards, reviewing pay and benefits. He was also introducing a new team building budget for all teams. He planned to arrange for more staff inclusion in clinical governance meetings, including inviting teams to make presentations at these meetings.

Patients and carers had access to up-to-date information about the work of the provider and the services they used. For example, through the provider website.

Staff had access to the hospital's intranet which held policies and documents relevant to their wards. This had been updated with more relevant information since the previous inspection including up to date guidance on working with patients who have eating disorders.

Learning, continuous improvement and innovation

Staff did not use quality improvement methods in their work. There were no quality improvement projects taking place on the ward.

Good

Specialist eating disorder services

The ward was planning to apply for accreditation under the Quality Network for Eating Disorders, standards set by the Royal College of Psychiatrists, following a successful mock-accreditation process a year earlier.

Senior management described work they were undertaking to assess the predictability of serious incidents at the hospital. They also described a project to look at introducing electronic tablets for staff on the wards to record observations, with a view to phasing out paper records.

Good

Substance misuse/detoxification

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

Are substance misuse/detoxification services safe?

Good

Safe and clean environment

Safety of the facility layout

The inpatient addiction service was set across two floors, on the third and fourth floors. All bedrooms had en-suite facilities. The fourth floor had been closed since December 2018. Environmental works were taking place on the fourth floor to install a security key fob system to the entrance to the ward, and it was not admitting patients.

The ward layout did not allow staff to observe all parts of the ward. There were blind spots on both floors, which staff mitigated by assessing patient risk, regular patient observations, and the use of convex mirrors.

Staff did regular risk assessments of the care environment. For example, nursing staff completed hourly environmental checks of the ward, and more in-depth weekly checks to assess whether any maintenance repairs were required.

The charge nurse had completed an up-to-date ligature risk assessment for the ward, which identified potential ligature points and actions to mitigate the risks. Staff had easy access to ligature cutters at the nursing station. Since the last inspection in January 2018, the hospital had completed ligature reduction work on the ward. This included replacement of bathroom fittings such as taps and doors. The hospital had put clear boxes over televisions in five of the patient bedrooms to reduce access to potential ligature points; this work was still to be completed in the remaining five bedrooms.

At the last inspection in January 2018, staff were not clear about ligature risks following a recent refurbishment. At this inspection, this was no longer the case. Staff were able to articulate the ligature risks on the ward and how these were managed.

The hospital completed weekly fire alarm tests on the wards. There were staff trained as fire marshals present on the ward. On both floors, the fire exits were locked and, under normal circumstances, they could only be opened by the charge nurse on duty who held the key. In the event of a fire alarm going off, the fire exits on the third floor automatically opened. However, on the fourth floor, the fire exits needed to be opened manually by a member of staff. At the time of inspection, there were no patients residing on the fourth floor. We raised this issue with the hospital director who advised that this decision had been made due to safety considerations relating to the height of the fourth floor, and patients would first be evacuated to the third floor in the event of a fire on the fourth floor.

The ward complied with guidance on eliminating mixed-sex accommodation. All bedrooms had en-suite facilities.

At the last inspection in January 2018, staff did not have access to an alarm system to summon assistance in an emergency. At this inspection, this was no longer an issue. The hospital had installed an alarm system and all staff had access to a personal alarm.

Maintenance, cleanliness and infection control

Good

Substance misuse/detoxification

The ward was visibly clean, had good furnishings and was well-maintained. The ward had a cleaner who cleaned the ward seven days a week. Cleaning records were maintained to demonstrate that the ward areas were cleaned regularly.

At the last inspection in January 2018, furniture and mattresses across the hospital were mostly fabric and not designed to be easy to clean. At this inspection, furniture and mattresses remained mostly fabric. Staff used mattress toppers to make mattresses easy to clean and prevent infection. However, there were no records of regular mattress checks, or the frequency of steam cleaning fabric furnishings.

Staff adhered to infection control principles. The ward provided a disinfecting hand gel dispenser on the wall near the entrance to the ward and the nursing station. There was a handwashing hygiene poster in the ward toilet, reminding staff how to wash their hands thoroughly.

Catering staff monitored the temperature of refrigerators for storing food and beverages in the patient kitchen to ensure good food hygiene.

Seclusion room

There was no seclusion room on the ward.

Clinic room and equipment

The third floor clinic room was visibly clean. It was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked the defibrillator daily.

Pabrinex was available to treat symptoms caused by a lack of vitamins, a frequent concern for this patient group, and there was provision for the treatment of anaphylaxis. Naloxone was stored on the emergency trolley in the event of an opiate overdose.

Staff maintained equipment well and kept it clean. Cleaning records for the clinic room and equipment were up-to-date. Staff recorded the temperature of the clinic room, which was within the appropriate range.

The clinic room on the third floor stored oxygen. However, there was no sign to inform staff and patients about the hazards of oxygen. This was raised with senior managers on the day of inspection, and an oxygen sign was immediately put up on the clinic room door.

Clinic rooms did not have examination couches so patients were examined in their bedrooms.

On the fourth floor, the clinic room had not been cleaned since the ward was last open in December 2018. The clinic room was not fit for purpose in its current state. the room. Patients were not at immediate risk, as at the time of the inspection the fourth floor was closed. The issue was raised with senior managers who confirmed staff were not using the clinic room and that managers planned to review the suitability of the clinic room.

Safe staffing

Nursing staff

The ward establishment for registered nurses was eight whole time equivalents, and two whole time equivalents for non-registered nurses. At the time of the inspection, there were three vacancies for registered nurses.

There were set staffing levels depending on bed occupancy. These were the same during the day and at night. At the time of the inspection, there were two registered nurses and a non-registered nurse to meet the needs of the three patients admitted to the third floor.

When necessary, managers deployed agency and bank nursing staff to maintain staffing levels. Between 1 September 2018 and 30 November 2018, bank staff covered 118 shifts and agency staff covered 123 shifts due to sickness, absence or vacancies. Staff said regular bank staff were used who were familiar to the ward and helped to ensure consistency of patient care. Staff told us that each shift had a permanent staff member working to promote consistency of patient care.

Between 1 September 2018 and 30 November 2018, permanent staff sickness overall for the ward was low at 5%. The staff turnover rate was low for the ward. There had been one staff leaver in the last 12 months.

Staff reported that staffing levels allowed patients to have regular one-to-one time with their key worker, and staff shortages rarely resulted in staff cancelling escorted leave or ward activities.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. A

ward doctor was shared between the third floor and eating disorder ward during weekday working hours. A resident doctor provided out-of-hours medical cover after 5pm and during the weekend.

The ward had a dedicated addictions specialist consultant (who was the hospital's medical director) who admitted patients to the ward, along with other consultants with admitting rights.

Mandatory Training

Staff had received and were up-to-date with appropriate mandatory training.

Overall, the completion rate for permanent staff was 81%. This included adult and children safeguarding. Training on managing violence and aggression, and life support training were both delivered face-to-face, and the rest was through online training.

At the last inspection in January 2018, staff were not sufficiently trained in interventions to protect patients from harm, including provision and use of naloxone, and action to take in the event of an alcohol withdrawal seizure. At this inspection, improvements had been made. Staff had completed formal specialist substance misuse training. Training records demonstrated 100% of staff had completed training in October 2018 in modules such as withdrawal scales, naloxone, the national early warning score, physical health associated with detoxification, and giving pabrinex injections. There was another specialist substance misuse training day planned on 17 May 2019, which all staff on the ward were scheduled to attend. Staff we spoke with could describe the purpose of the medicine naloxone. Naloxone is a potentially life-saving medicine when used in settings associated with opiate misuse and overdose. We saw evidence that managers discussed naloxone in team meetings and supervision sessions.

However, managers did not have robust systems in place to assure themselves that staff had embedded the knowledge and skills delivered in the substance misuse training. Since our previous inspection, the hospital had developed competencies for nurses working on the addictions unit, which were in line with the Royal College of Nursing guidelines. Competencies included gastro-intestinal nursing and diabetes. However, competencies were not substance misuse specific, and did not cover key areas, such as the recognition and management of Wernicke's encephalopathy, controlled drugs used in substance misuse services and assessing and managing withdrawal from different substances.

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed six care records during our inspection. A nurse and doctor completed comprehensive assessments of the person's drug and/or alcohol dependence level, healthcare and other needs, in a timely manner, before treatment started. This included the alcohol use disorders identification test (AUDIT), which assessed alcohol consumption, drinking behaviours and alcohol-related problems. The clinical opiate withdrawal scale (COWS) was used to rate common signs and symptoms of opiate withdrawal. Staff also completed a physical health examination, included cardiovascular and respiratory measured. This ensured staff were able to recognise and respond to warning signs and deterioration in patients' health.

Two out of the six patient care records we inspected were patients who had received treatment for drug and/or alcohol detoxification. Appropriate detoxification tools were used and physical health was regularly monitored, which included blood pressure, pulse, respiratory rate. There was clear communication between the staff and the patients' GPs.

The nurse and doctor completed a risk assessment for each patient when they were admitted. Staff screened for comorbid mental health conditions, such as depression, anxiety and suicide risk. Staff asked patients if they presented any risks to themselves or other people, or if they were at risk from other people. If the patient identified risks, staff classified these as being low, medium or high. The assessment then stated the level of observation that the staff needed to provide to manage the risk. The form showed whether the patient had consented to that level of observation.

Staff updated risk assessments daily, based on a discussion between the nurse and the patient about how the patient was feeling that day. The nurse and patient both signed a daily risk assessment. If staff identified any risks as medium or high, the staff created a risk management plan.

Management of risk

Good

Substance misuse/detoxification

The ward had access to a medical doctor 24-hours, seven days a week. This meant there was medically directed evaluation, care and treatment of substance misuse disorders on the ward. Staff on the ward managed risks associated with withdrawal from alcohol and/or opiates by using appropriate detoxification tools, such as COWS for opiates, and the clinical institute withdrawal assessment for alcohol scale assessment (CIWA) for alcohol.

Staff were aware of and dealt with specific risk issues. At the last inspection in January 2018, there had been an identified risk of illicit substances being brought onto the ward. At this inspection, staff said this was not a current issue. Staff were clear about the steps being taken to try and prevent illicit substances being brought into the hospital and used by patients. For example, visitors signed in when they visited the hospital and the reception alerted the ward of the visitor and whether they were allowed on the ward. Staff informed visitors about the restrictions on contraband. The hospital had brought specially trained sniffer dogs onto the ward to check for presence of illicit substances.

Nurses had received training in effective searching, and searched patients on admission and when they returned from leave. Searches involved patients emptying their pockets and staff looking through their bags. Staff searched patients' bedrooms if they suspected there were items that could present a risk, such as drugs, alcohol or sharp objects. Patients were subject to a urine drug screen (UDS) on admission and a random UDS weekly, and breathalysed each time they returned from leave.

Staff followed policies and procedures for use of observation. The service provided four levels of observation, which were dependent on patient need. Nurses agreed the level of observation with the ward doctor and consultant. Nurses could increase, but not reduce, the level of observation without the agreement of a doctor.

At the last inspection in January 2018, staff had not completed early exit plans specifying the information that should be provided to patients if they left treatment early. At this inspection, this was no longer an issue. Staff regularly explained to patients the risks around early exit from treatment. This was discussed upon admission, and in weekly ward rounds. If a patient decided to exit their treatment early, staff gave them an appropriate discharge plan.

At the last inspection in January 2018, patients undergoing detoxification were not sufficiently protected from harm, restrictions on leave from the hospital were not always implemented and physical health monitoring was not always carried out. At this inspection, we found this was no longer an issue. The hospital had clear guidelines in place to ensure patients undergoing detoxification were protected from harm. Staff provided patients with detoxification guidelines on admission, which informed them that they would be kept under observation by the medical and nursing staff, and outings would not be permitted during the first 48-hour assessment period. From the patient care records we inspected, staff had completed physical health examinations for each patient on admission.

The service had naloxone guidelines in place and considered patients' individual need in regard to offering naloxone upon discharge. Patients who were admitted for detoxification from injectable opiates were always discharged with naloxone packs, and instructed in its use and administration prior to their discharge. Patients who were admitted for detoxification from opiate tablets would be risk assessed and may be prescribed naloxone packs if they were considered to be at risk of overdosing.

The hospital was not smoke-free and had a smoking area on-site. Best practice guidance recommends that hospital facilities should be smoke-free.

Informal patients could leave the ward at will and knew this. Staff informed patients of their rights as an informal patient on admission and throughout their stay. However, staff discouraged patients from leaving the ward in the first 48 hours of their admission whilst the initial assessment was taking place. Staff escorted patients who wanted to leave the ward if necessary.

Use of restrictive interventions

Staff said it was rare for any patient to require a physical intervention. Prior to the inspection, there had been two episodes of restraint within the last 12 months. This involved a patient who had general psychiatric illness alongside substance misuse issues. The restraints did not involve the prone position or rapid tranquilisation. The patient had since been transferred to a psychiatric intensive care unit which was better able to support their needs. We inspected one of the restraint records, which

demonstrated that it had been correctly reported as an incident and included the reason for the restraint, location of the restraint holds, restraint timeframe and confirmed that senior staff had been informed.

There were no reports of use of rapid tranquilisation during the last 12 months on the ward.

Staff applied blanket restrictions on patients' freedom only when justified. Staff informed patients of the ward guidelines upon admission, These were consistent with providing a therapeutic environment for patients to complete their detoxification from drugs and alcohol. For example, the service did not permit patients to bring drugs or alcohol onto the ward, or to use drugs or alcohol whilst on leave. If patients brought illicit drugs onto the ward, the clinical team discussed the implications with the patients, and it could result in discharge from the hospital and involvement from the police. If patients consumed alcohol and/or drugs on leave, they were unable to continue with the therapeutic groups for 24 hours, and would be advised to cooperate with urine and breathalyser testing.

The service did not permit patients to enter other patients' bedrooms for reasons of safety. The service only permitted visitors between 5pm and 10pm so there was space for therapeutic activities. Staff completed random urine drug screens on patients. Staff discussed these blanket restrictions with patients upon admission and patients were asked for their agreement. At the same time, patients were informed of their right to leave the ward during their treatment, but were advised this would not be in their best interests within the first 48 hours.

Safeguarding

Staff were trained in safeguarding, knew how to raise a safeguarding concern, and did that when appropriate. The service had a policy on safeguarding for children and for adults. Staff knew who the hospital safeguarding lead was.

Staff could give examples of how to protect patients from harassment and discrimination.

Staff knew how to identify adults and children at risk of or suffering harm. This included working in partnership with other agencies. Staff identified any risk to children cared for by patients on the ward during the admission process. Safeguarding issues were routinely discussed at handover meetings and ward rounds.

Children were normally able to visit the ward during visiting hours if an adult accompanied them.

Staff access to essential information

Staff used a combination of paper and electronic records to record patient information. All information needed to deliver patient care was available to relevant staff when they needed it and was in an accessible form. Agency staff were given a unique login to access patient electronic records.

Medicines management

Prescriptions and medication administration records were clear and included important information such as allergies, dose changes, indications for use and maximum doses of medicines prescribed 'when required'. Each time staff administered medicines they signed the record (or coded to show why the dose had been omitted).

The hospital had an in-house pharmacist who was responsible for medicines reconciliation, supplying and stocking of medicines on the ward, and also disposal and transportation of medicines. The pharmacist visited the ward weekly.

The drugs cupboard was secure. The controlled drugs register was clear and up-to-date. Staff knew the contact details for the controlled drugs accountable officer and reported to them any significant events or incidents relating to controlled drugs. Staff disposed of controlled drugs appropriately.

On the third floor, staff monitored the temperature of the medicine fridges daily, and items in the fridges were in-date. However, we found staff stored their personal drinks in the medicine fridge. This was not good practice, and we raised the issue with senior managers on the day of the inspection.

Staff reviewed the effects of medication on patients' physical health regularly and in line with the National Institute for Health and Care Excellence (NICE). For example, they monitored blood pressure, pulse and respiratory rate when patients were prescribed pharmacological treatments to enable detoxification.

Track record on safety

The hospital did not report any serious incidents within the addictions unit during the last 12 months.

Good

Substance misuse/detoxification

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. Staff said they completed incident forms when incidents occurred. These were passed to the charge nurse and the nurse in charge of the hospital.

Staff reported all incidents that they should report. For example, incidents of restraint and medicines errors.

Staff received feedback from investigation of incidents at the service. At the previous inspection in January 2018 we found that there was a need for improvement in ensuring all staff received learning from incidents. During the current inspection we found that managers sent staff a learning bulletin via email that outlined lessons and any actions from incidents. This learning bulletin was also displayed on notice boards around the hospital. Managers discussed learning points from incidents with staff during regular supervision sessions.

There was evidence that changes had been made as a result of feedback. For example, the ward had a locked cabinet next to the nursing station where patients could charge their electrical goods. This charging cabinet was installed on the ward due to a previous patient ligature incident involving an electrical charger.

Staff reported that they did not always receive a debrief following challenging incidents on the ward. This was also noted in the ward's team meeting minutes from July 2018. Debriefs following an incident are important to identify areas for improvement, and can help to alleviate any emotional impact on the staff involved.

Are substance misuse/detoxification services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Clinicians completed a comprehensive assessment of the person's drug and/or alcohol dependence level, healthcare and other needs, in a timely manner, before treatment started. This included the alcohol use disorders identification test (AUDIT), which assessed alcohol consumption, drinking behaviours and alcohol-related problems, and opioid withdrawal tools, such as clinical opiate withdrawal scale (COWS).

The assessment was in-depth and covered patients' mental and physical healthcare needs. This included assessment for comorbid mental health conditions, any present psychiatric contacts and forensic history. Staff conducted physical observations, which included urine drug screening and liver function testing, and assessed their medical history.

Staff assessed patients' physical health needs in a timely manner after admission. This included baseline bloods, temperature, pulse, and physical examinations, such as respiratory and cardiovascular, to help inform treatment.

The prescriber had conducted a face-to-face assessment of the patient before issuing the first prescription and before making any changes to the prescription.

Staff also assessed the patients' social needs, such as housing, education and employment, family, faith, legal and financial support.

Staff developed care plans that met the needs identified during assessment. Care plans were personalised, holistic and recovery-oriented. Staff developed care plans with patients during admission, and care plans clearly stated patients' views and wishes. Patients' recovery care plans included risk management plans.

Staff updated care plans when necessary, and the multidisciplinary team and patient reviewed care plans weekly during ward round.

Best practice in treatment and care

The service had a comprehensive alcohol and drug detoxification policy in place, which had recently been updated and was in line with national guidance. The hospital provided staff on the ward with specific substance misuse training to ensure staff were aware of the NICE guidance when monitoring the physical status of people undergoing detoxification or withdrawal. Leaders on the ward attended a monthly addictions steering group where best practice was often discussed,

Staff provided a range of care and treatment interventions suitable for the patient group.

Good

Substance misuse/detoxification

Relevant staff members understood the National Institute for Health and Care Excellence (NICE) and Department of Health and Social Care (DHSC)guidance that describe best practice in detoxification or withdrawal and used appropriate tools and scales. For example, the clinical opiate withdrawal scale (COWS) for opiate and the alcohol withdrawal assessment scoring guidelines (CIWA) for alcohol. At the last inspection in January 2018, staff were not clear about the validated tools to use for patients on detoxification from different substances. At this inspection, this was no longer the case. Staff used the appropriate validated tools for the substance the patient was receiving treatment for.

The prescriber used medicines recommended by NICE and the DHSC as the first line of treatment.

The service had a clear policy in place to ensure all patients undergoing alcohol detoxification were prescribed a thiamine regime to reduce the risk of neurological damage.

Staff routinely offered blood-borne virus testing to patients on admission.

The service provided a meaningful activity and therapy programme relevant to the needs of the people using the service that was available seven days a week. This included anger management, relapse prevention and relationships. The service supported patients to complete the first three steps of the 12-step recovery programme. The service provided cognitive behaviour therapy, motivational enhancement therapy and interpersonal therapy.

The service also provided art and dance therapy, yoga, mindfulness and chi kung.

The service provided free aftercare for addictions patients after discharge from the hospital, which was available in the form of weekly group therapy sessions.

We inspected six patient care records during our inspection. Of these care records, one patient had received treatment for alcohol detoxification and one patient had received treatment for opioid detoxification. The records showed staff ensured that patients had good access to physical healthcare. Nurses carried out physical observations. If a patient required specialist care and treatment then they were referred to a specialist doctor at the local hospital and supported to attend appointments if necessary.

However, in one patient's care records their vitamin D blood results were very low, and no action had been taken to manage the low result. This was raised with staff during the inspection who took action and prescribed the patient vitamin D supplements.

When patients were on dose reduction schedules, staff took the person's needs into account. For example, their physical health status and psychiatric history. Staff monitored and recorded the patient's physical health status at regular intervals during withdrawal, which included blood pressure, pulse and respiratory rate.

Staff assessed and met patients' needs for food and drink. Staff ensured catering staff were made aware of any dietary requirements.

Staff supported patients to live healthier lives. For example, they supported patients with smoking cessation if required by offering nicotine replacement therapy.

Staff used recognised rating scales to assess and record severity and outcomes for patients. For example, health of the nation outcome scales (HoNOS), which measures the health and social functioning of people with mental illness. Staff used the clinical outcomes in routine evaluation measure (CORE), which measures psychological distress. Staff also used the hospital anxiety and depression scale (HADS) and the Beck's depression inventory to measure anxiety and depression.

Staff participated in clinical audits to maintain quality control. Audits included clinic room checks and medicines charts. However, staff on the ward were unable to access the results of recent audits during the inspection. There was therefore a disconnect between audit findings and staff awareness of them, with no clear evidence of changes made as a result.

Skilled staff to deliver care

The team had access to the full range of specialists required to meet the needs of patients on the addictions ward. This included addiction specialist consultant psychiatrists, an addiction specialist ward doctor, registered, and non-registered nurses, pharmacist, and specialist addiction therapists, including clinical psychologists, cognitive behavioural therapists, family therapists and an occupational therapist.

Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient

Good

Substance misuse/detoxification

group. Staff received specialist in-house training for their role on an inpatient detoxification facility. All staff on the ward were scheduled to attend another in-house addictions training day in May 2019. Prescribers were qualified and competent to assess and prescribe for addiction issues. These were medical doctors on the ward. There were no non-medical prescribers on the ward.

Managers provided new staff with appropriate induction. The hospital provided new staff with an overall induction to the hospital, and the addictions team offered new staff a specific induction to working on the addiction ward.

Managers provided staff with supervision. We inspected two staff members supervision records which demonstrated supervision was of a good quality and followed a structured agenda. The meetings covered topics such as learning points from incidents and ligature risk management.

The percentage of staff that received regular supervision was 82% in the last year, and 100% in January and February 2019.

Staff had access to team meetings, although these were not happening as regularly as they should have been. Staff told us team meetings were meant to happen monthly, but there had been three in the last six months. The team meetings did not follow a structured agenda, but did discuss important topics, such as pabrinex and naloxone awareness, and care plan documentation. The team meeting minutes were handwritten and difficult to read, which meant staff who were not at the meeting may have found it difficult to read what was discussed.

At the last inspection in January 2018, staff did not have regular appraisals. At this inspection, there had been an improvement. Eighty percent of staff had received an appraisal.

Multi-disciplinary and inter-agency team work

Staff held weekly multidisciplinary ward rounds to discuss patients' progress with care and treatment. The meeting followed an agenda, which included essential items such as reviewing risk levels, medicines, physical and psychological progress and discharge planning. Staff gathered patients' views and concerns ahead of the ward round to inform the discussion.

Staff shared information about patients at handover meetings twice a day when there was a change in shift.

Staff recorded handwritten handover notes in a book. The quality of the handover notes varied and did not follow any structure. Some handover notes were very brief and did not always detail key information about the patient's progress during the previous shift.

Staff described good working relationships with teams outside of the hospital, such as community mental health teams and GPs. We found that permission to contact GPs was being requested on admission. This was to help ensure that poly-pharmacy and double prescribing was avoided. Staff said that if patients refused GP contact, it was at the consultant's discretion as to how to proceed. However, the service still did not have a clear policy, or waiver, for the possible risks involved when treating patients who did not consent to information sharing.

Good practice in applying the Mental Capacity Act

The hospital had a policy on the Mental Capacity Act (MCA). Staff knew where to get advice from within the hospital regarding the MCA. Staff had received training in the MCA.

Patients on the ward had given their consent to treatment and had been given sufficient information about treatment options and risks and had the capacity to make an informed decision. Staff gave patients verbal and written information regarding their care and treatment on admission, and the nurse and doctor completed an assessment of their capacity to consent to admission and treatment. Staff said that the service occasionally admitted patients with impaired capacity due to alcohol intoxication. In these situations, staff would monitor the patient to ensure their safety and wait for the patient to regain capacity once the effects of alcohol had worn off.

The hospital policy stated that if a patient entered the hospital, this could be interpreted as implied consent to admission. The policy also stated that any action on behalf of a person who lacks capacity, even temporarily, must be completed in the person's best interest.

Are substance misuse/detoxification services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Good

Substance misuse/detoxification

Patients we spoke with were very happy with the nursing support they received. They described staff as respectful, compassionate and caring. However, patients said that sometimes agency staff were not always clear on the ward rules, which led to some confusion.

The ward had an 'information and inspirational messages' book where patients could leave comments before they were discharged from the ward. The messages were overwhelmingly positive, stating the treatments had been helpful and relevant, and the nursing team were always caring and patients enjoyed making connections with other patients in the therapy groups.

Staff supported patients to understand and manage their care and treatment. We saw evidence of this on patient admission, in weekly ward rounds, and daily sessions with nursing staff.

Staff had a good understanding of the patients on the ward and could tell us about the circumstances of their admission and details of their care and treatment.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the ward and to the service. Staff gave patients an admission booklet specific to the addictions ward. It contained information on the multidisciplinary team, therapy programme, and expectations for residing on the addictions ward.

From the patient care records we inspected, it was evident that staff involved patients in care planning and daily risk assessments. Staff obtained patients' views on their goals and needs during the admission. Staff asked for patients' views ahead of ward rounds by asking them to complete a ward round review form, which the multidisciplinary team discussed.

Staff communicated with patients so that they understood their care and treatment. For example, the hospital's pharmacist led an 'ask the pharmacist' discussion group on a weekly basis, which provided patients with an opportunity to have a discussion about any aspect of their medicines.

Staff enabled patients to give feedback on the service they received. Staff facilitated weekly community meetings with patients, where they could give feedback and discuss any concerns. Staff recorded minutes from these meetings. Minutes from the most recent community meeting stated that staff were warm and caring, and that the patient would not be here if it was not for the staff team's interventions and warm welcoming.

Staff ensured that patients could access independent advocacy. An advocate visited the ward twice a week.

Involvement of families

Families and carers were welcome to visit the ward during visiting hours, if patients wanted them to do so. They could meet on the ward or in visiting rooms off the ward.

The service facilitated a family support group every Tuesday evening aimed at families, partners and friends of people suffering from an addiction problem. A therapist experienced in addictions facilitated the meeting.

The service held a monthly family day for addiction patients. The family day was led by a therapist experienced in addictions. It consisted of two groups, one group for family and partners only, and then the second group brought together the families, partners and the patient. It provided a forum for everyone to express their thoughts and feelings.

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

Good

Access waiting times and discharge

The addictions unit was for 24-hour, medically directed evaluation, care and treatment of substance misuse disorders.

Patients were usually self-referred or referred by their GP to the ward. The hospital had an admissions team who would assess the referral and decide whether it was appropriate. The service had alternative care pathways and referral systems in place for people whose needs could not be met by the service.

The service was able to see urgent referrals quickly.

Good

Substance misuse/detoxification

There was no waiting list for the ward. The average bed occupancy on the ward was low, at 47% between 1 June 2018 and 30 November 2018. The average length of stay between 1 December 2017 and 30 November 2018 was 13 days.

The service did not admit new patients to bedrooms that were allocated to patients on leave.

Occasionally, the service admitted patients from the general acute psychiatry service when they had combined addiction issues.

Discharge and transfers of care

There were no delayed discharges from the ward in the last 12 months.

Staff started patients' discharge planning on admission. Staff liaised with the patient's GP or community psychiatrist during the discharge planning process.

Staff developed a discharge plan for patients, and this was reviewed weekly at the patient's ward round. Staff conducted a 'courtesy call' with all patients shortly after discharge to check how they were doing.

Staff supported patients during referrals and transfers between services, for example, if they required treatment in an acute hospital.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms, which were en-suite. They could personalise their bedrooms if they wished.

There were facilitates for patients to store their belongings securely.

Patients had access to the full range of rooms and equipment to support treatment and care. Therapy groups took place each day in the therapy department off the ward. Patients had their meals in the restaurant shared by all the patients at the hospital.

There were quiet areas on the ward where patients could meet visitors. Patients could also meet visitors in their bedrooms. Patients could make a phone call in private.

Patients had unrestricted access to an outside courtyard within the hospital until 10pm. The outdoor space was pleasant, with a water feature and potted plants. There was a designated smoking area in one section of the courtyard.

Patients had access to other activities outside of the medical and psychological programme. This included massage therapy, relaxation groups and a sleep and energy group.

Patients had access to an on-site gym, where a fitness instructor offered an initial assessment and recommended an exercise programme.

Patients could make hot drinks and snacks at any time. The ward kitchen was stocked with tea and coffee, a water cooler, milk, bread, butter and jams. Patients could request food and snacks from the restaurant at any time during the day.

Patients' engagement with the wider community

Staff supported patients to maintain contact with their families and friends. Staff encouraged patients to access the local community, for example details were provided for local places of worship, places of interest, parks, and self-help groups for addictions.

Patients had access to local alcoholics anonymous, narcotics anonymous, cannabis anonymous and gambling anonymous groups and were encouraged to attend these groups, following treatment.

There was also an outreach programme available to patients after discharge, and evening sessions were held every week.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients. For example, there was a lift to both floors so that the wards could be accessed by people using a wheelchair.

Staff were able to give examples of supporting patients who identified as lesbian, gay, bisexual and transgender (LGBT+).

Staff ensured patients could obtain information on treatments, local services, patients' rights and how to complain. This was included in the patient admission handbook and via a variety of patient leaflets on offer on the ward. Patients were given an information leaflet about local services and places of interest around the hospital. This included places of worship (churches, a mosque and a synagogue). Staff provided patients with a self-help group leaflet that detailed contacts for mutual-aid groups in the community to support people with addictions.

Good

Substance misuse/detoxification

This was an international service that admitted patients from across the United Kingdom and other countries, for example, the Middle East. Staff were sensitive to patients' cultural needs, and identified cultural needs during the admission assessment. The service routinely provided information in other languages and arranged interpreters.

Meals were provided in a restaurant used by all patients at the hospital. Food was prepared and cooked by a chef on-site. Meals could be ordered to meet the specific cultural needs, dietary needs and preferences of the patients.

The service did not have a dedicated spiritual room on-site. However, staff arranged spiritual support if patients requested this.

Listening to and learning from concerns and complaints

Patients we spoke with said they knew how to make a complaint if they needed to do so. Information on how to make a complaint was included in the patient admission booklet and was displayed in the communal areas of the ward.

In the last 12 months, the ward had received two complaints. Of these two complaints, both were upheld. The themes of the complaints were around not being happy with weekend therapy, and a patient not being happy with their multidisciplinary team.

At the last inspection in January 2018, complaints were not always addressed appropriately and staff were not always informed of the learning from incidents at the hospital. At this inspection, we saw that complaints were being addressed appropriately and fairly. The hospital aimed to acknowledge complaints within 48 hours and respond within 20 days.

During this inspection, we reviewed a sample of five complaint files including in progress and closed cases. The responses were thorough and addressed all areas of complaint, the language was sympathetic and the provider apologised where necessary.

At our last inspection, complaint responses did not include information on the next steps to take if unsatisfied with the response. During the current inspection, complaint responses included contact details for the independent sector complaints adjudication service. Two complaints from 2018 went through the adjudication process and were partially upheld. In the 12 months from December 2017 to November 2018 the hospital overall received 34 complaints, six of which were upheld, and one of which was referred to the ombudsman.

The service received a high volume of compliments (82) between 1 September 2018 and 30 November 2018.

Are substance misuse/detoxification services well-led?

Good

Leadership

Leaders provided clinical leadership. The consultant psychiatrist for the ward was an addiction specialist and had been working in the field of addictions since 1992.

The nursing team was led by a charge nurse, who worked three days a week on the ward. The hospital had identified a gap in leadership on the ward during the days when the charge nurse was off. The hospital had created and advertised for a new ward manager post for the addictions ward. The ward manager would be able to provide full-time and more senior leadership support to the ward.

Leaders had a good understanding of the ward. They could explain clearly how the team was working to provide high quality care. Staff had a clear definition of recovery and that was shared and understood by all staff.

Leaders were visible in the service and approachable for patients and staff. Leadership development opportunities were available. Staff were encouraged to apply for the ward manager post. Staff also had access to courses to help develop their leadership skills, such as root cause analysis.

Since the previous inspection a new hospital director was in post, who had made a number of changes to the governance of the service. He identified immediate challenges relating to the facilities and nurse leadership, and had introduced ward manager posts and a head of facilities post to address these issues.

Vision and strategy

Good

Substance misuse/detoxification

Staff knew and understood the vision and values of the team. Staff were centred on supporting patients through their addictions, promoting relapse prevention, and where appropriate, working together with patients and their families.

Staff demonstrated the organisation's values of respect, teamwork, compassion, commitment and recognition throughout their work. Patients feedback demonstrated that staff were caring and committed to helping them to get better.

The hospital director had recently introduced the role of staff and patient representatives to promote more staff and patient input into the running of the hospital. Staff told us that there had been a big improvement in the quality of their work and the service provided to patients since our last inspection.

Culture

Staff we spoke with said they felt respected, supported and valued by the hospital. Staff said they felt proud to work for the hospital. Staff reported that the therapy programme offered to patients was particularly good.

Staff reported good morale within the addictions team. Staff on the addictions ward sometimes completed shifts on the eating disorder ward and the general psychiatrist wards. Staff told us that these teams worked well together.

Staff said they felt listened to by senior managers. They felt they were able to raise concerns without fear of retribution.

Staff appraisals included conversations about career development and how it could be supported.

Governance

Leaders attended a monthly addictions steering group, which provided an opportunity to discuss a range of relevant topics, such as detox medicines, substance misuse training and the addictions therapy.

At the last inspection in January 2018, there were insufficient governance processes to identify areas for improvement promptly. At this inspection, we found improvements had been made. For example, managers sent staff a learning bulletin via email that outlined learnings and any actions from incidents. This learning bulletin was also displayed on notice boards around the hospital. Managers discussed learning points from incidents with staff during regular supervision sessions. Staff were now receiving regular appraisals.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts.

Staff understood the arrangements for working with other teams, both within the hospital and externally, to meet the needs of the patients.

The hospital had an appropriate structure of committees to oversee the quality of care delivered. The quality performance management group was attended by the senior leadership team, lead consultants and, sometimes, by representatives from the French provider organisation. This provided an opportunity to discuss a range of relevant topics. Each month the senior clinical staff from the ward and senior hospital managers met at a steering group. This meeting was to discuss emerging trends on the ward, training requirements for the team and feedback from carers and patients. Senior and operational managers met weekly, and a charge nurse forum was held every month. Staff and patient representatives met with the senior management team regularly. The range of staff attending quality improvement meetings had expanded to include a charge nurse, and we were advised that pharmacy would soon be represented too.

Since the previous inspection the provider had arranged for more audits to be undertaken, and was planning to produce a schedule of audits across the hospital. Although we found evidence that a number of relevant audits were undertaken by staff on a regular basis, staff on the ward were unable to access the results of recent audits during the inspection. There was therefore a disconnect between staff undertaking audits, with no clear evidence of changes made as a result.

The hospital director had produced a structured estates plan for the hospital, providing clarity over funds available, so that the management team could make proactive plans for future improvements.

Management of risk, issues and performance

The charge nurse did not have access to the risk register. However, they were able to raise concerns to the senior charge nurse if required. Staff concerns matched those on the risk register.

Good

Substance misuse/detoxification

A number of improvements had been made to the ward environment, including provision of more anti-ligature fittings in bedrooms and en-suite bathrooms, locked charging towers for patients' mobile phones, and convex windows to address blind spots. Closed circuit TV was being installed in communal areas at the time of the inspection. Senior management had made the decision to introduce controlled access to the hospital wards, in order to improve safety for patients.

The provider had a system for monitoring consultant psychiatrists' practising privileges at the hospital. The system included detailed information of all required checks undertaken, and when they were due to be renewed. However, at the time of the inspection, the information indicated that six of 69 consultants had not provided evidence of their renewed General Medical Council registration, and 17 had not provided evidence that they had up to date medical indemnity insurance. We discussed this with the hospital director, who provided assurance that consultants who had not provided this information were not able to see patients at the hospital. However, he acknowledged that there was some room for improvement to ensure that the system flagged any consultant who did not have all required checks in place, and undertook to address this.

Following the inspection, the hospital director provided evidence that a new monthly review had been established to clarify whether the hospital needed to suspend or revoke any consultant's privileges. Following this a new updated list would be sent to the patient services and senior management teams.

Information management

The service used systems to collect data from the ward that was not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. Agency staff were given their own personal login so that they were able to access electronic care records.

Patients' paper care records were stored in an open plan nursing station and were not kept in a locked compartment. This meant there was a risk that a patient or a visitor could potentially obtain another patient's care record. This was raised with staff on the ward who said there was usually a member of staff in the nursing station at all times which would prevent this happening.

Information was in an accessible format, and was timely, accurate and identified areas for improvement. Information governance systems included confidentiality of patient records. However, the use of both paper and electronic patient records resulted in some unnecessary duplication, which impacted on the time staff had to spend with patients.

Charge nurses had some limitations on information available to support them with their management role. For example, they did not have access to audits findings on the performance of the service, staffing and patient care.

The provider recognised when incidents needed to be reported to external bodies, including the CQC. Since the previous inspection, the provider was providing more detailed information about incidents and actions taken as a result.

Engagement

Staff, patients and families had access to up-to-date information about the work of the hospital and the services they used. For example, staff had access to the hospital's intranet and regular learning bulletins. Patients and carers had access to regular forums with staff where they could discuss pertinent issues.

Patients and carers had opportunities to give feedback on the service they received. For example, a patient representative for the addictions ward attended a monthly meeting with the senior management team, where they expressed any concerns or wishes. The minutes from this meeting were displayed in the communal area of the ward for patients and staff. Families and carers were able to attend the weekly family support group for addictions, where they were able to ask questions to members of staff regarding their experience.

Managers and staff had access to the feedback from patients as the forum meeting minutes were displayed on the ward, and staff recorded minutes from the weekly community meetings in a book on the ward.

Patients were asked to complete a patient satisfaction survey and the results were collated for 2018. The survey results showed patients were positive about the treatment they received from nurses, doctors and therapists. In addition, there were comment boxes in each ward.

A staff survey had taken place in December 2018 to January 2019. This showed that overall there has been a decline in

the number of staff participating, although the majority of answers remained positive. Areas of concern raised included levels of pay, internal communication, work with bank staff and annual leave arrangements for therapists. Suggestions included more use of the intranet, and possible upgrading of the hospital's computer systems.

The first staff representatives meeting was held in the week before the inspection, and an inbox to receive suggestions for improvements at the hospital was planned. Meetings were scheduled to be held monthly. The hospital director advised that senior management would work closely with staff representatives to address staff concerns. Changes being considered included possible relocation of the staff room closer to the wards, reviewing pay and benefits. He was also introducing a new team building budget for all teams. He planned to arrange for more staff inclusion in clinical governance meetings, including inviting teams to make presentations at these meetings.

Learning, continuous improvement and innovation

Staff did not use quality improvement methods in their work. There were no quality improvement projects taking place on the ward.

Senior management described work they were undertaking to assess the predictability of serious incidents at the hospital. They also described a project to look at introducing electronic tablets for staff on the wards to record observations, with a view to phasing out paper records. They also advised that they were piloting virtual ward rounds on the addictions ward, so that each consultant could review their patients every week.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff fully implement procedures to prevent banned items from being brought onto the wards. Regulation 12(2)(b)

Action the provider SHOULD take to improve

- The provider should have robust systems in place to assure themselves that staff have embedded learning from the specialist substance misuse and specialist eating disorders training. Nursing competencies for the addiction unit should be substance misuse specific, and those for the eating disorder service should be specific to the care of patients with eating disorders.
- The provider should ensure that staff are provided with a debrief and receive support following a serious or challenging incident.
- The provider should ensure that staff meetings are held on a regular basis including standard agenda items related to quality and safety, with a clear record of the meeting made available to the staff team.
- The provider should ensure that staff have easy access to legible, accurate and up to date information about patients when they are admitted to the service, and at shift handovers.
- The provider should ensure that patient records are kept locked away at all times when not in use.
- The provider should ensure that there is a system in place to check mattresses and all soft furnishings on a regular basis, and record when they are steam cleaned.
- The provider should ensure that there is a system in place to ensure that staff on all wards are aware of the results of recent audits, and take appropriate action to bring about improvements.
- The provider should ensure that staff are provided with training in working with patients who have autism.
- The provider should ensure that there are current risk assessments and care plans in place for day patients in the eating disorder service, and that greater detail is recorded in discharge plans for patients with eating disorders.
- The provider should ensure that there is a system for reviewing any blanket restrictions on the wards, such as locking laundry and activity room facilities when not in use.
- The provider should review the route taken by patients on the eating disorder ward to access the hospital restaurant, to ensure that this does not impact on their comfort and dignity.
- The provider should consider adopting a smoke-free policy in line with best practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured care was always provided in a safe way for service users by ensuring that banned items were not brought onto the wards.** This was a breach of regulation 12(2)(b)