Nightingale Hospital

Quality Report

11-19 Lisson Grove, Marylebone
London NW1 6SH
Tel: 020 7535 7700
Website: www.nightingalehospital.co.uk

Date of inspection visit: 15, 16, 17, 19, 21 January 2018
Date of publication: 03/05/2018

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We conducted a comprehensive inspection and rated the specialist eating disorder service at the Nightingale Hospital as Requires Improvement.

We conducted focussed inspections of the other core services to check on progress with meeting the regulations. We did not re-rate these core services. We were unable to inspect the children and adolescent mental health (CAMHS) ward, as it was closed.

- When we inspected the Nightingale Hospital in February 2017, we rated the hospital as requires improvement and found breaches of four regulations, two of which had still not been met at the current inspection. We found significant additional concerns relating to these two regulations, and breaches of a further four regulations at the current inspection.
- At the previous inspection in February 2017, we found that staff were not provided with an alarm system for use to summon assistance in an emergency. This had not been addressed by the time of the current inspection, although alarms had been ordered.
- At the previous inspection in February 2017, we found that staff were not clear about the ligature risks and the management plans on each ward to mitigate risks. This remained a concern at the current inspection, although work had been undertaken to reduce ligature risks across the hospital.
- At the previous inspection in February 2017, we found that staff had insufficient training in their roles supporting patients with addictions, and eating disorders. This remained a concern at the current inspection. We also found that staff were not clear about the validated tools to use with patients on detoxification from different substances. Staff did not sufficiently protect patients undertaking detoxification from harm as they were unclear about action to take in the event of alcohol withdrawal seizures or opiate overdose.
- At the previous inspection in February 2017, we found that staff were not having annual appraisals. This was still not happening at the time of the current inspection.
- At our previous inspection in February 2017 we found that on the mixed sex acute ward, there was no female only lounge in line with recommendations from national guidance on same sex wards. During this inspection, we found that there was still no female only lounge on this ward or risk management plan in place to address this issue.
- Staff were not storing, administering and monitoring patients' medicines safely.
- The provider had not fully addressed all actions from the most recent fire risk assessment within the deadline set.
- There were insufficiently rigorous infection control systems in place to ensure that all areas of the wards were clean.
- There were insufficiently robust governance and quality assurance processes in place to identify areas for improvement promptly. The provider had not carried out an appropriate level of planning and risk assessment before the eating disorder ward moved location.
- A review was needed of procedures and processes to reduce illicit substances being brought into the hospital and to ensure these were followed by all staff.
- Complaints were not always addressed appropriately, complainants were not told about the steps to take if they were not satisfied with the provider's response.
- The provider did not have an effective system in place to ensure staff knew about and learned from incidents. Staff team meetings were not held on a regular basis and there was no standard agenda covering learning from incidents.
- Insufficiently rigorous recruitment checks were carried out for new staff, such as obtaining two written references.
- Improvements were also needed in the following areas; recording mental capacity assessments, ensuring informal patients on the eating disorders ward had clear information about their right to leave the ward and access fresh air and in storing patient records securely.

However:

- At the previous inspection in February 2017, we found that staff were not receiving regular supervision

Summary of findings

sessions. We found that this had improved at the current inspection. We also found an improvement in notifying the Care Quality Commission of safeguarding alerts raised with the local authority.

- At the previous inspection in February 2017, we found that a generic assessment was in use on the substance misuse and detoxification ward, which meant they did not have detailed information about the patient's history of drug or alcohol use. A detailed substance misuse risk assessment was in place at the time of the current inspection, including prompts to check safeguarding arrangements for any dependants, and permission to contact the patients' GP.
- At the previous inspection in February 2017, we found that in the substance misuse and detoxification ward, the staff did not routinely offer patients tests for blood borne viruses (BBV) and did not keep adrenaline on its emergency medication trolley. Adrenaline was available as appropriate at the current inspection and we found improvements in offering patients BBV screening.
- Most patients were positive about the therapies available to them and spoke highly of the level of support provided by staff across the hospital.
- There was a positive reporting culture for when things went wrong.

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	Requires improvement 	The hospital had not successfully addressed several areas highlighted as a concern in the last inspection in February 2017. These included some environmental risks. For example, ligature risks were present on the wards and staff were unable to show us where ligature points were or how risks could be mitigated. Alarm systems for staff to use in an emergency were not adequate. Infection control arrangements did not meet the required standard. Staff had not received an annual appraisal and the provider did not have systems in place to ensure that staff were made aware of lessons learned from incidents. Team meetings were not held regularly across all wards and the standard agenda did not include all pertinent issues. Medication was not always prescribed or administered correctly and we found some out of date medicines on each of the three wards. Patients were not involved in the development of their care plans. Care plans were generic and capacity assessments were not decision specific. However: Improvements had been made with the number of staff who had received supervision. Staff were maintaining records of where patients were in the hospital as part of their hourly checks and mandatory training compliance had improved.
Child and adolescent mental health wards	Requires improvement 	Service closed at time of inspection.
Specialist eating disorders services	Requires improvement 	The hospital had not successfully addressed several areas highlighted as a concern in the last inspection in February 2017. This included not having robust infection control management, comprehensive ligature risk assessments and management plans or suitable processes for embedding learning from incidents.

Summary of findings

Staff did not store and dispose of medicines in line with best practice. Staff did not replace expired items in the clinic room in a timely way.
There was no paperwork to assure us how the hospital was assessing and managing infection control risks on the ward.
There was no system to ensure that staff kept up-to-date and to check they were delivering care in the way the provider expected. The hospital did not provide specialist training in eating disorders or support staff with a core competency framework. Staff did not receive regular appraisals to identify and address areas for development or progression.
The recent relocation of the ward had not been planned and managed well by senior staff. The resultant changes impacted on patient experience, for example, the loss of direct access to fresh air.
The provider had not addressed several action points within required time scales following a recent fire risk assessment.
A review of staff records showed recruitment checks for medical professionals had not always taken place or been repeated within necessary timescales.
However:
A multidisciplinary team supported patient care and were able to offer a range of therapies in line with national guidance.
Patients gave positive feedback about the quality of nursing and therapeutic input.
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.
Staff provided appropriate emotional support to patients during mealtimes and offered education sessions on food and nutrition as part of a weekly timetable.
Staff involved patients in risk assessment and risk management and kept up to date recovery orientated care records.

Substance misuse/ detoxification

The hospital had not successfully addressed several areas highlighted as a concern in the last inspection in February 2017. The hospital had not

Summary of findings

yet provided staff with an alarm system to summon assistance in an emergency and staff were not clear about ligature risks following a recent refurbishment. Infection control systems were not sufficiently rigorous to ensure that all areas of the wards were clean. 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. They were not clear about the validated tools to use for patients on detoxification from different substances. Staff did not have regular appraisals.

Patients undertaking detoxification were not sufficiently protected from harm, restrictions on leave from the hospital were not always implemented, physical health monitoring was not always followed through and early exit from treatment plans were not in place.

There were insufficiently robust governance processes to identify areas for improvement promptly. Complaints were not always addressed appropriately and staff were not always informed of the learning from incidents at the hospital.

The hospital had not addressed all actions within their assessor's recommended timeframe following the most recent fire risk assessment.

However:

The service had improved the quality of risk assessments and screening for new patients on the ward.

Staff were caring towards patients and responsive to their needs. The level of supervision provided to staff had improved. Patients had access to a range of therapies that they found helpful.

Summary of findings

Contents

Summary of this inspection

Page

Background to Nightingale Hospital 9
Our inspection team 9
Why we carried out this inspection 9
How we carried out this inspection 10
What people who use the service say 11
The five questions we ask about services and what we found 12

Detailed findings from this inspection

Mental Health Act responsibilities 18
Mental Capacity Act and Deprivation of Liberty Safeguards 18
Overview of ratings 18
Outstanding practice 54
Areas for improvement 54
Action we have told the provider to take 56

Requires improvement

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 and general psychiatry and eating disorder treatment to young people (adolescents), as well as outpatient services.

The service provides three acute wards for adults of working age, one child and adolescent mental health ward, a substance misuse and detoxification ward and a specialist eating disorder service for adults. All wards provided mixed sex accommodation. The hospital has 80 beds over the six wards.

At the time of our visit, there were 40 patients admitted to the hospital over five wards. The second floor of the hospital, which had been a general acute ward, was closed for refurbishment. A separate nine-bedded three-storey building which had been the young person's unit was functioning as the eating disorders unit (EDU) since September 2017. The EDU 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 an 11 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 February 2017. The overall rating for the hospital at that time was requires improvement.

Our inspection team

The team that inspected the Nightingale Hospital comprised 15 people. This included one CQC head of hospital inspections, four CQC inspectors, a Mental Health Act reviewer, eight specialist advisors (consisting of three consultant psychiatrists, four senior nurses, and a governance specialist), and two experts by experience. The experts by experience were people who 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 that inspection we rated the service as **Requires improvement** overall.

When we inspected the service in February 2017, we rated acute wards for adults of working age and children and adolescent mental health services as **Requires improvement** overall. We rated these core services as **Requires improvement** for safe and effective and **Good** for caring, responsive and well-led. We inspected but did not rate the substance misuse and eating disorder wards.

Following the February 2017 inspection, we told the provider it must make the following actions to improve:

- The provider must ensure that staff have adequate access to support by ensuring that an effective system is put into place for staff to access assistance from other staff in an emergency.

Summary of this inspection

- The provider must ensure all ligature risks are identified on wards and that all staff have access to the ligature risk management plan and can clearly articulate how they manage ligature risks on each ward.
- The provider must continue to ensure that ligature risks are reduced by refurbishing the environments of the wards where ligature risks are still present by December 2017.
- The provider must implement a supervision policy and ensure that nursing staff receive regular supervision and appraisal.
- The provider must ensure there are effective systems to address concerns about poor performance.
- The provider must ensure that all grades of staff working on the CAMHS and the substance misuse and detoxification ward are provided with formal specialist training to work in these specialist services.
- The provider must ensure that all grades of staff who have contact with children first complete children safeguarding training.
- The provider must notify the Care Quality Commission of all statutory notifications, including allegations of abuse.
- The provider must ensure that staff know where patients are in the hospital at all times as there is a potential of risk from patients harming themselves or others.
- The service must ensure there are effective systems in place to manage the risks of patients on the substance misuse and detoxification ward who do not consent to the service contacting their GP.
- The service must ensure that assessments on the substance misuse and detoxification ward address the specific needs and background risk and misuse histories of people admitted for drug or alcohol detoxification.
- The provider must ensure that screening for blood borne viruses is provided on the substance misuse and detoxification ward.
- The service must ensure that any risks to children cared for by patients are identified when patients are admitted.
- The service must ensure emergency medicines, such as adrenaline for anaphylaxis, are on the substance misuse and detoxification ward.

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

Regulation 12 Safe care and treatment

Regulation 13 Safeguarding service users from abuse and improper treatment.

Regulation 18 Staffing

and

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the Nightingale Hospital.

During this unannounced inspection visit, the inspection team:

- visited five wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 19 patients who were using the service
- interviewed the hospital director, compliance manager, medical director, nursing services manager, human resources manager, deputy hospital director and hotel services manager
- spoke with the charge nurse or senior staff on each of the wards
- spoke with 39 other staff members; including doctors, nurses, occupational therapists, dietitians, pharmacists and domestic staff

Summary of this inspection

- attended and observed three hand-over meetings and one staff supervision group
- looked at 26 care and treatment records of patients
- attended and observed one meal on the eating disorders ward
- checked medication management on all of the wards
- reviewed 10 complaints, 17 incident reports and two incident investigation reports
- reviewed 10 files for consultants who have practicing privileges and eight 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 19 patients who were accessing the inpatient or day patient facilities at the time of inspection.

Patients were very positive about the staff 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. However, they said that some bank nurses who worked night shifts were not always friendly.

Most patients we spoke with were pleased with the amount and quality of the therapeutic support they received and said that the therapies on offer had a positive impact on their recovery. However, some patients told us that they wanted more one-to-one therapies.

Some patients told us they were not involved in the decision making about their care and they did not have a copy of their care plan.

Patients told us that the environment was comfortable and clean and they felt safe in the hospital.

On the substance misuse and detoxification ward, patients said staff managed the symptoms of their withdrawal well and they had felt safe throughout the process.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- At our previous inspection in February 2017, as well as our inspection in 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 this inspection, we found that wards did not have wall-based fixed alarms and staff did not have personal alarms. However, managers had recently purchased personal alarms for staff and they were expected to be delivered and in use within the following two months.
- At our previous inspection in February 2017, we found there were ligature risks throughout the wards and staff were unable to explain how these would be mitigated. Maintenance work was being undertaken to reduce ligature risks, however, staff were still unable to explain where some of the remaining ligature risks were located.
- At our previous inspection in February 2017, we found that, on the mixed sex ward, there was no provision for a female only lounge, and there was no relevant risk management plan to protect patients from potential harm. During this inspection, we found that there was still no female only lounge on the mixed sex ward.
- At the previous inspection in February 2017, we found that staff had insufficient training in their roles supporting patients with addictions and eating disorders. This remained a concern at the current inspection. Staff did not sufficiently protect patients undertaking detoxification from harm and were unclear about action to take in the event of alcohol withdrawal seizures or opiate overdose.
- Clinic rooms, including the fridges which contained patient medication, were not always clean. Cleaning staff did not keep records or schedules for cleaning.
- The most recent infection control audit for the hospital was not available at the time of the inspection, so we could not be sure how the hospital was assessing and managing infection control risks.
- Furniture and mattresses across the hospital were mostly fabric and not designed to be easy to clean.
- There was no clear record of actions to address the issues identified as part of a recent fire safety assessment.
- Patients were not always prescribed and administered medication in line with national guidance.

Summary of this inspection

- Staff on the eating disorders ward did not assess patients for risk of pressure sores, which can be a problem for people of very low weight.
- Staff were not made aware of the learning from incidents across the hospital.
- The provider had not ensured all recruitment checks were in place for all staff and medical professionals.

However:

- At the last inspection in February 2017, we found that safeguarding training was low across all wards. At this inspection, we found that staff were up to date with most mandatory training, including safeguarding.
- At our previous inspection in February 2017, we found that that staff did not always know the whereabouts of patients within the hospital, this time systems had been developed to ensure they knew.
- At the previous inspection in February 2017, we found that in the substance misuse and detoxification ward, the staff did not routinely offer patients tests for blood borne viruses (BBV) and did not keep adrenaline on its emergency medication trolley. Adrenaline was available as appropriate at the current inspection and we found improvements in offering patients BBV screening.
- At the previous inspection in February 2017, we found that a generic assessment was in use on the substance misuse and detoxification ward, which meant staff did not have detailed information about patients' history of drug or alcohol use. A detailed substance misuse risk assessment was in place at the time of the current inspection, including prompts to check safeguarding arrangements for any dependants and evidence of permission to contact the patients' GP.
- Staff assessed most patients' risks on admission and staff and patients completed daily risk assessments. Plans to manage risks were 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.
- Comprehensive portable electrical appliance checks were taking place during the time of the inspection. This was previously carried out by in-house staff, but was now contracted out to an external company.

Summary of this inspection

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- At the last inspection in February 2017, we found that the level of staff who had received an appraisal was not adequate. At this inspection, we found that there had been little improvement in the number of staff who had received an appraisal.
- At the previous inspection in February 2017, we found that staff had insufficient training in their roles supporting patients with addictions and eating disorders. This remained a concern at the current inspection, and we found that staff were not clear about the validated tools to use for patients on detoxification from different substances.
- On the eating disorders ward, staff were not supported by a core competency framework or specialist training to ensure care was delivered consistently and to the highest quality.
- The service did not have a formal link with acute hospitals in order to manage the acute physical health needs of patients with a very low weight, which is a recommendation from the guidance for the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN).
- On the specialist eating disorders ward, although informal patients had a legal right to leave the ward, the ward was locked and patients had to ask staff to unlock two doors to leave the ward. Feedback from some patients was that at times, they had to wait for staff to become available to unlock the doors. This impeded their rights to leave the ward when they wished.
- Patient care plans were generic and patients had not been involved in the development of their care plan.
- Mental capacity assessments, when undertaken, were not decision specific.

However:

- There was a diverse multi-disciplinary team in place.
- Staff who were new to the service received an induction.
- At the last inspection in February 2017, we found that the level of staff who had received supervision was not adequate. At this inspection we found that the completion of supervisions had improved.
- On the eating disorders ward, staff assessed patients in a timely way and created recovery orientated care plans with patients and updated these regularly. They included physical health needs that related to their eating disorder and refeeding syndrome.

Summary of this inspection

- On the eating disorders ward, the multidisciplinary team met weekly to discuss patient care and involved patients and their families in discussions, when patients consented.
- The service offered therapies in line with national guidance and employed a dietitian and an occupational therapist.

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 had an understanding of their individual needs and they felt comfortable approaching them.
- On the eating disorders ward, we saw that staff supported patients well during mealtimes. Records showed patients were involved in decisions about their care, as well as family members when the patient consented. 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.
- Patients had access to an advocate and knew how an advocate could support them to be involved in their care and decision making.

However:

- On the eating disorders ward, the suggestions box on the ward was an open box, so anyone could access the suggestions. This meant other patients and all staff could read the suggestions at any time which could impact on the writer's anonymity.
- There were no information leaflets available on the eating disorders ward at the time of inspection, which staff said was due to the ward move three months earlier.

Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because:

- On the eating disorders ward, in order to get fresh air, patients had to ask staff to unlock two doors and leave the ward. There was no outside space that could be accessed directly from the ward.

Summary of this inspection

- In a sample of complaints we looked at, not all responses addressed all areas of complaint and a small number were not appropriately sympathetic. Responses did not include information on the next steps to take if unsatisfied with the response.
- Poor logistical planning on the eating disorders ward led to an inappropriate mealtime experience for some patients who ate lunch and dinner in the main hospital restaurant. Also, meal plans were decided on the day the dietitian did not work, which led to last minute changes that could be distressing to the patient group.
- The eating disorders service did not have written exclusion criteria.

However:

- Length of stay was discussed clearly from the point of admission and patients were made aware of the funding packages which applied to them.
- A weekly timetable included a range of activities that supported the recovery and wellbeing of the patient. These were adjusted following feedback from different patients over time.
- Patient bedrooms were well decorated and all had en-suite facilities. Patients could store their possessions safely on the ward.
- Patients spoke positively about the food provided within the hospital.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- The provider had not successfully addressed several areas of concern highlighted at the last inspection in February 2017, including safety concerns.
- At the previous inspection in February 2017 we found that staff were not receiving annual appraisals. This was still not happening at the time of the current inspection.
- There were insufficiently robust governance and quality assurance processes in place to identify areas for improvement promptly.
- A review of procedures and processes was needed to reduce illicit substances being brought into the hospital and to ensure the measures in place are followed by all staff.
- Senior staff had given ward staff less than four days' notice when the eating disorders ward moved from one building to another. This did not allow enough time for comprehensive review of potential risks associated with the move or the new environment. The move impacted on some elements of day to

Summary of this inspection

day care for patients, and these impacts had not been considered or addressed at the time of inspection. For example, loss of direct access to fresh air and disrupted meal management.
- Staff did not engage in clinical audit, so did not have a lot of data about the quality of care delivered on the wards or how things could be improved.
- Learning from incidents was not embedded in ward systems; staff did not discuss this regularly at team or other meetings.
- The provider did not always include all significant details in notifications to the CQC about incidents.

However:

- 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.
- There were systems in place to gather some data centrally, and a positive incident reporting culture.

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.

At the time of the inspection, there were two patients detained under the Mental Health Act (MHA) in the hospital. The remaining 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 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. Staff did not make it clear enough to informal patients that they had the right to leave the ward. This was highlighted as a concern at the last inspection.

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 in the six months prior to 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 if 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. However, the capacity assessments being used were generic, and did not indicate for which particular decision capacity was being assessed, such as admission or taking prescribed medicines.

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 enters the hospital, this can 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.

Staff said that if they had any questions about the Mental Capacity Act they would speak to the hospital compliance manager.

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	Requires improvement	Good	Good	Good	Requires improvement
Child and adolescent mental health wards	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Specialist eating disorder services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Substance misuse/ detoxification	N/A	N/A	N/A	N/A	N/A	N/A
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

We did not rerate the acute mental health wards on this occasion. We did not inspect the children and adolescents mental health ward on this occasion. We do not currently rate substance misuse services.

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

Requires improvement

Safe	Requires improvement
Effective	Requires improvement
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

- The wards in the main building were all unlocked. Patients could easily access all parts of the hospital, including other wards, the restaurant, therapy rooms in the basement and the courtyard. The main entrance to the hospital was kept locked at all times. There was a buzzer system in place for patients and staff to access or exit the building.
- At our previous inspection in February 2017, as well as our inspection in 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 this inspection, we found that wards had wall-based fixed alarms that alerted staff on their ward only. In addition, managers had recently purchased personal alarms for staff and they were expected to be delivered and in use within the following two months. Medical staff, as well as one nurse on each ward, carried a bleep which could be used to alert other bleep-holders, and there were telephones strategically positioned throughout the hospital.
- At our previous inspection in February 2017, we found that there were ligature risks throughout the wards in patients' bedrooms, bathrooms, corridors and communal spaces and staff were unable to explain how these would be mitigated. The wards were in the process of being upgraded and ligature reduction work was taking place. This included the replacement of bathroom fittings such as taps and doors. Despite this work, the bedrooms and en-suite bathrooms still contained a significant number of ligature points, as did the wider hospital environment. Patients moved around the hospital for meals and to attend therapy groups. The wards completed environmental checklists which included consideration of ligature risks. However, when asked, staff were not able to clearly articulate the location of all ligatures anchor points on the ward and how they would minimise the ligature risks for patients, for example, through increased observations.
- At our previous inspection in February 2017, we found that on the mixed sex ward, there was no female-only lounge. This was not in line with recommendations from national guidance. At this inspection, we found that there was still no female-only lounge on the mixed sex ward or mitigations in place. Women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse. We also found that patient bedrooms were used for their one to one meetings, because there was no quiet room where these meetings could take place.

Maintenance, cleanliness and infection control

- Most areas within the ward environment were visibly clean and clutter free. However, we noted that the clinic rooms, including the fridges which contained patient medication, were dirty. We raised our concerns with the managers who took prompt action to ensure these areas were thoroughly cleaned.

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

Requires improvement

- Cleaning staff worked across the hospital. They did not have a list of tasks to complete on each shift. There was no evidence that their work was monitored on a regular basis to ensure they carried out cleaning tasks at the correct frequency and to the required standard.
- At the last inspection in February 2017 we found that the provider did not have an infection control lead and had not carried out an infection control audit since May 2016. At this inspection, we found that the provider had appointed an infection control lead, however, the lead was not available at the time of inspection. We were also told that the hospital completed two infection control audits a year, but the records of these were unavailable in the absence of the infection control lead.
- Records showed that checks for legionella took place on a monthly basis and that there were no significant concerns.
- Furniture and mattresses throughout the hospital were mostly fabric-covered and not designed to be easy to clean. This increased the risk of infection. Some patients described how they had been asked to take additional precautions as a patient on the unit had a blood-borne disease. While it was appropriate to advise patients to follow good hygiene practices in hospital, we were concerned that they were in receipt of such specific information.
- Staff used yellow plastic bins to dispose of needles and sharps. The yellow bins in the treatment rooms were dated and not over-filled. This was good practice.
- We observed staff adhering to infection control principles, including handwashing and wearing appropriate personal protective equipment, such as disposable gloves.
- In June 2017 a fire safety assessment had been completed by an external provider with specific experience of under-taking this work. This assessment concluded that the 'risk to life from fire at these premises was moderate'. It gave a list of actions to complete immediately, within one month and within three months. We were told that some actions had been completed, but there was no clear record of this and so it was not possible to be assured about the fire safety at the hospital. In addition, we observed that patients had placed towels over a number of bedroom doors to prevent them from slamming shut. This would compromise safety in the event of a fire.
- Comprehensive portable electrical appliance checks were taking place during the inspection.

Clinic room and equipment

- Each ward had a clinic room. However, the clinic rooms were not tidy or well organised. We found out-of-date medication and disposable equipment past its 'use by' date. We raised this with the provider during our inspection who took prompt action to re-organise the clinic rooms.
- Staff kept emergency lifesaving equipment in the treatment room. Wards 1b and 1b had access to an emergency trolley situated in their shared clinic room. Records showed that staff checked emergency equipment weekly. Staff had access to one set of ligature cutters on each ward, but the ligature cutters on ward 1b were very small and only suitable for cutting a thin ligature. The ground floor ward kept its ligature cutters uncovered and hung on metal hooks in the clinic room, which meant that when they were required they were not immediately to hand.
- Staff maintained medical equipment stored in the clinic rooms, but we found that some equipment had not been calibrated, for example, weighing scales. We also found that the ground floor did not have access to a blood glucose monitor. All other equipment was labelled with the date it was last checked and calibrated. We raised our concerns with the provider who assured us that prompt action would be taken.
- We were told that staff cleaned equipment after use and weekly, although there was no cleaning schedule in place. Staff had not labelled medical equipment with the date they had last cleaned it.

Safe staffing

Nursing staff

- In January 2018, 86% of qualified nursing staff shifts were covered by permanent staff and 14% were covered by bank staff. For healthcare assistants, 47% of the staff were bank workers, although this was a small team of staff and there had been some long term sickness.

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

Requires improvement

Medical Staff

- The provider had 55 consultants with practising privileges, the hospital sometimes referred to these as 'admitting rights'.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. At the time of the inspection nine of the 55 consultants had outstanding checks and for most there was a record of when these would be updated. This was overseen by the medical director, who, if needed, contacted the individual consultant. For a few consultants he had agreed delayed submission of documents, for example, if they were unwell. Ultimately he withdrew practicing privileges if checks were not satisfactorily completed and there were examples of when this had taken place.

Recruitment checks

- We looked at the recruitment checks for eight staff who had recently started working at the hospital. Of these, two staff had started working with no written references, four had only one reference and two had both references. All the staff had a completed Disclosure and Barring Service check and provided evidence of their professional registration where needed. A new system was being put into place to ensure recruitment checks were completed prior to the start of employment and updated when required.

Mandatory training

- At the last inspection in February 2017, we found that uptake of safeguarding training was low across all wards. At this inspection, we found that staff had received and were up to date with most mandatory training. The provider was closely monitoring the completion of mandatory training. The completion rate for permanent staff was over 95%. This included adult and child safeguarding. Bank staff were also able to access the training. Training on managing violence and aggression and life support were both delivered face-to-face, staff completed other mandatory training online.

Assessing and managing risk to patients and staff

Assessment of patient risk

- During the inspection, we reviewed the risk assessments of 13 patients across the three wards.
- Staff had completed risk assessments on admission for each patient. Staff had reviewed each risk assessment on a regular basis and updated patients' risk assessments as required.

Management of patient risk

- Staff were aware of, and dealt with, the specific risk issues presented by each patient and observed patients in accordance with policy.
- At our previous inspection in February 2017, we found that that staff did not always know the whereabouts of patients at risk of self-harm or harm to others within the hospital. The hospital policy on observation, the 'Safe, Supportive Observation and Engagement with Patients at Risk' policy, stated that the location of all patients should be known to staff at all times. This policy applied to both informal and detained patients and was in line with NICE guidelines on safe observation of patients. At this inspection, we found that staff performed hourly checks on all patients (or more frequently if enhanced observations were required). Staff recorded the whereabouts of patients every hour, including if they were out with family or friends, and we saw evidence of this.
- Staff told informal patients on the wards that they were free to leave at any time. Staff also placed this information by the entrance to each of the wards as a reminder.
- From looking at records of patient incidents and speaking to staff and patients, it was evident that illicit substances were being brought into the hospital and this was a significant challenge for staff to manage. On the acute wards there was a lack of clarity about the steps being taken to try and prevent illicit substances being bought in and used by inpatients. However, the staff we spoke with described how they searched patients on admission and targeted their searches at other times if there was cause for suspicion.

Use of restrictive interventions

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

Requires improvement

- At the last inspection in February 2017, we found that physical health checks following rapid tranquilisation were not consistently completed. At this inspection, we found that there had been no rapid tranquillisation in the previous 12 months.

Safeguarding

- A safeguarding policy was in place; however, this did not make reference to all relevant national guidance. The safeguarding policy was last reviewed in August 2015 and, although it contained appropriate information, it did not refer to issues such as female genital mutilation or child sexual exploitation.
- Staff were trained in safeguarding, knew how to make a safeguarding alert and did this when it was appropriate. At the last inspection in February 2017, we found that the hospital was not consistently notifying all allegations of abuse to the Care Quality Commission. During this inspection, we found that, since January 2017, 19 safeguarding alerts had been made by the hospital. The hospital's compliance manager kept a log of safeguarding alerts and from this it could be seen that the referrals were appropriate. For some patients who were still in contact with the hospital, the provider had contacted the relevant parties to get feedback on the actions taken in response to the alert.

Staff access to information

- Staff used dual paper and electronic systems to document patient records.

Medicines management

- Staff did not always store medicines, including controlled drugs, safely.
- Medicines were stored in a locked clinic room. However, we identified that the fridges used to store medicines were not lockable. It is good practice for fridges and cupboards which contain medicines to be kept locked, where non-qualified staff, or others, may be able to access the area where medicines are stored. We found some medicines on each of the wards which were out of date. We raised this with the provider who took prompt action to dispose of the medication during our inspection. The provider also assured us that locks would be purchased for the fridges.
- We reviewed the medication records for 24 patients and found that for six patients, staff had administered medication in excess of the amount recommended by national guidance. These errors occurred due to poor prescribing practice. Patients had been prescribed a medication to take at night, but the prescriptions did not state that this amount should not be exceeded within 24 hours. For example, a patient was given one dose 11pm and had their next dose administered at 10pm the following evening. Patients therefore received amounts in excess of the maximum limit. We raised this with medical and nursing staff at the time of inspection.
- At the last inspection in February 2017, we found that fridge temperatures were monitored daily and seen to be in range. However, minimum and maximum temperatures were not checked to ensure the medicines had remained at the safe temperature throughout. At this inspection, we found that staff had not consistently recorded the minimum and maximum temperatures to determine whether or not temperatures were out of range at any point. We also found that when fridge temperatures had been recorded as out of range, staff had failed to take action or report this. Staff had incorrectly stored some intravenous medication on ward 1a. This medication, which should be stored at room temperature, had been stored in the fridge; this may have caused unnecessary discomfort when administered to a patient.

Track record on safety

- The provider notified the Care Quality Commission of six serious incidents in the last year. There was one inpatient death, one allegation of sexual abuse and four patients who seriously harmed themselves either shortly after discharge or whilst receiving outpatient care from the hospital.

Reporting incidents and learning from when things go wrong

- There was a positive incident reporting culture and staff reported, on average, 40 incidents each month. The most common incidents related to the use of illicit substances or self-harm. Other frequent incidents involved patients absconding and medication errors.

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

Requires improvement

- The incident reports, which were hand-written, gave staff the opportunity to reflect on any learning from the incident. Some staff completed this in full and others lacked detail.
- The hospital compliance manager completed an analysis of all the incidents. This considered the number and types of incidents, as well as factors such as the time the incident took place. The analysis also reviewed the outcomes and areas for improvement. This report was discussed at the monthly quality performance management group.
- At the last inspection in February 2017, we found that most staff could not describe any learning from incidents. Incidents were meant to be discussed at ward team meetings, but records of these meetings showed this was not happening consistently. In any case, team meetings were held infrequently, which meant that staff had few opportunities to formally discuss incidents or complaints. At this inspection, we found that the compliance manager shared the analysis of incidents with the charge nurses on each ward. However, when asked, most ward staff were unable to describe the incidents which had occurred and the changes that had been made as a result.
- For serious incidents, the hospital usually appointed an external professional to lead the investigation or sought guidance from external legal advisors. The reports produced used a root cause analysis format, but the recommendations in the reports appeared quite limited. The provider said they waited for feedback from the coroner to add to the recommendations.

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

(for example, treatment is effective)

Requires improvement

This was a focused inspection and we did not consider all aspects of effective.

Assessment of needs and planning of care

- We reviewed eight care and treatment records during our inspection; staff developed care plans for each patient that met the needs identified during the initial assessment of the patient. Staff regularly reviewed patient care plans; however, there was no evidence in seven of these care plans that staff had involved patients or relatives in the development of their plan. Patients gave mixed reports about their involvement in care planning.
- Care plans were not personalised, holistic or recovery oriented. Most patient care plans were generic and lacked person-centric recovery goals. The care plan for one patient did not address the risks identified. This patient had a secondary addiction to alcohol, which had been identified through the risk assessment process, but staff had not developed a care plan to support the patient with this issue.

Best practice in treatment and care

- This was a focused inspection and we did not consider this as part of the inspection.

Skilled staff to deliver care

- The team included, or had access to, the full range of specialists required to meet the needs of patients on the ward. There was daily medical and nursing cover; occupational therapists, clinical psychologists and therapists also supported the wards.
- The human resources team offered all new staff a brief induction. Staff who joined some teams were also offered more in-depth training. This varied between teams, specific ward based induction programmes were not available to all.
- The nursing services manager had proposed an on-line training programme with the Royal College of Nursing as a way of delivering on-going learning and development for the nursing staff. This proposal was awaiting approval at time of inspection.
- At the last inspection in February 2017, we found that the level of staff who had received supervision and appraisal was not adequate. At this inspection, we found that the number of staff who had received regular supervision had improved and records were kept, however, this was not happening to a consistent standard across all acute wards.
- Across the wards the completion of staff appraisals was very low. The provider was reviewing the appraisal

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

Requires improvement

process and considering the introduction of a new recording format. They recognised that they needed to move away from a 'tick box exercise' to a meaningful process for all the staff.

Multi-disciplinary and inter-agency team work

- This was a focused inspection and we did not consider this as part of the inspection.

Adherence to the MHA and the MHA Code of Practice

- This was a focused inspection and we did not consider this as part of the inspection.

Good practice in applying the MCA

- Each patient's consultant was responsible for assessing their capacity and this formed part of the admission process. The nurses and the admitting doctor also shared this responsibility. However, there were 55 consultants with practicing privileges who were not directly employed by the service. As a result, there was not one single approach to assessing and reviewing patients' capacity, and it varied according to the consultant. This meant there was a risk of inconsistency and it added a level of complexity for nursing and other staff who had to be mindful of each patient's capacity for decision-making.
- At the previous inspection in February 2017, we found that staff had not completed mental capacity assessments consistently or comprehensively. During this inspection we reviewed the capacity assessments of eleven patients. We found that most patients were assessed as having capacity, however, the forms used to assess a patient's capacity related only to their admission to hospital and agreement to treatment. The Mental Capacity Act 2005 states that decisions should be time and decision-specific; the hospital forms did not include space to record additional decisions and were therefore not compliant with this requirement.

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

Good

This was a focused inspection and we did not consider all aspects of caring.

Kindness, privacy, dignity, respect, compassion and support

- We saw staff engaging positively with patients on the wards during the inspection. Patients on each ward told us they thought staff were caring but bank staff who worked on night shifts were not always friendly.
- Staff demonstrated good knowledge and understanding of patients' needs.
- We observed staff knocking and waiting before entering a patient's room.

Involvement in Care

Involvement of patients

- Staff orientated new patients to their ward during the admission process. Patients received an information booklet on admission that included information about the ward and their rights.
- Staff involved patients in care planning and risk assessment on admission, however, most patients told us that they were not involved with their care planning after the admission process. Some patients did not have a copy of their care plan.

Involvement of families and carers

- This was a focused inspection and we did not consider this as part of the inspection.

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

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

Requires improvement

Good

This was a focused inspection and we did not consider all aspects of responsive.

Access and discharge

Bed Management

- This was a focused inspection and we did not consider this as part of the inspection.

Discharge and transfers of care

- At the previous inspection in February 2017, we found that patient records did not include a discharge plan. During this inspection, we found that there was no standardised process to plan for a patient's discharge. We reviewed the records of 13 patients and found that four patients had a proposed discharge date and three patients had some discharge goals set. The staff we spoke with told us that discharge planning did not usually start until the patient was ready to go home. This meant that patient care may not be recovery focussed which could impact on their progress.
- Patients with a dual diagnosis, where an addiction was secondary to their mental health diagnosis, were treated on the acute wards. There was no clear early exit strategy in place to protect patients if they left the service prior to their agreed discharge date. This meant that patients may not be given appropriate advice on how to care for themselves and mitigate the risk of unintentional overdose after leaving the service.

Facilities that promote comfort, dignity and privacy

- This was a focused inspection and we did not consider this as part of the inspection.

Patients' engagement with the wider community

- This was a focused inspection and we did not consider this as part of the inspection.

Meeting the needs of all people who use the service

- This was a focused inspection and we did not consider this as part of the inspection.

Listening to and learning from concerns and complaints

- This was a focused inspection and we did not consider this as part of the inspection.

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

Good

This was a focused inspection and we did not consider all aspects of well-led.

Leadership

- Staff said that senior staff visited the wards regularly and managers were approachable and supportive.
- Staff told us that they were not aware of any bullying or harassment within the service.
- Staff knew how to use the whistle blowing process and said they could raise concerns without fear of victimisation.

Vision and strategy

- Staff across the hospital overall demonstrated the organisation's values of respect, compassion, commitment, teamwork and recognition throughout their work. Patients spoke very positively about the respect and compassion they displayed.

Culture

- Nurses said they spoke to the charge nurses if there were any issues they needed to raise.
- An initial staff survey had taken place in late 2017 across the hospital overall. This showed that many staff felt positive about working for their team and the hospital. However, it also indicated that the communication between the senior leadership team and other staff in the hospital, especially bank and sessional therapists, could be improved. The leadership team were considering how this could be addressed and were planning to introduce a hospital newsletter.
- Opportunities for staff to offer views on the service were limited due to the infrequency of team meetings.

Governance

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

Requires improvement

- The hospital did not have a clear framework for the discussion of important information such as learning from incidents, complaints, audits and alerts. At the last inspection, we found that team meetings were rarely held. At this inspection, we found that staff met as a team, although the frequency of meetings varied between wards. Staff discussed a range of topics, such as staffing or general housekeeping. However, other pertinent issues were not presented or discussed at team meetings, such as learning from incidents.
- The hospital's assurance processes were not yet ensuring that areas for improvement were identified and addressed in a timely manner. Instead the provider was responding in a reactive manner to regulators and other external stakeholders.
- At the last inspection, we found that compliance with mandatory training was below 70% and that staff had not received regular supervision or appraisal. At this inspection, we found that improvements had been made with the completion of mandatory training as well as staff receiving regular supervision. Most staff had not received an annual appraisal.

Management of risk, issues and performance

- At the previous inspection in February 2017, we found that the provider did not have an effective system for grading incidents and accidents to quickly identify those that were serious, nor did they systematically share 'lessons learned' with staff. At the current inspection, we found that there was a strong culture of reporting incidents and accidents. These were assessed by senior management who identified any learning to prevent a reoccurrence. However, this learning from these was still not always shared with relevant staff across the hospital.

Information management

- At the previous inspection in February 2017, we found that the provider was not completing all statutory notifications to the Care Quality Commission (CQC), including allegations of abuse. At the current inspection, there was evidence that the provider recognised when incidents needed to be reported to external bodies, including the CQC. However, the incident reports frequently did not contain enough information for the CQC to understand the exact nature of the incident and the actions taken by the provider. This meant that the inspector often needed to ask for further information and gave the impression that the provider was not being open and transparent about incidents, contrary to the approach expected from a well-led hospital.
- The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. The charge nurses were required to collate and submit data to various central teams, such as human resources. Charge nurses were provided with monthly reports on the most frequently reported incidents for their ward.

Engagement

- Patients across the hospital were asked to complete a patient satisfaction survey and the results were collated. This survey had been completed on paper, but from February 2018 will be available on-line. There was a target satisfaction score of 96% and from July to October 2017 this score was just missed. The survey results showed patients were positive about the treatment they received from nurses. In addition there were comment boxes in each ward. Any comments were passed to the hospital director. In some cases he responded to the individual patients but the findings did not feed systematically into patient feedback processes.

Commitment to quality improvement and innovation

- The hospital was working towards gaining accreditation with the Royal College of Psychiatrists for some of the core services they provided.

Requires improvement

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Requires improvement

The ward was closed at the time of the inspection.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

The ward was closed at the time of the inspection.

Are child and adolescent mental health wards caring?

Good

The ward was closed at the time of the inspection.

Are child and adolescent mental health wards responsive to people's needs?

(for example, to feedback?)

Good

The ward was closed at the time of the inspection.

Are child and adolescent mental health wards well-led?

Good

The ward was closed at the time of the inspection.

Requires improvement

Specialist eating disorder services

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

Are specialist eating disorder services safe?

Requires improvement

Safe and clean environment

Safety of the ward layout

- The ward layout did not allow staff to observe all parts of ward due to some blind spots. This risk was mitigated by individual risk assessments and set levels of staff observation for each patient. This ranged from once every hour to constant observation. The ward was in a separate building to the rest of the hospital, which was locked.
- At the last inspection of the hospital in February 2017, we found that staff did not always have access to ligature risks assessments on wards, or ligature risk management plans that clearly identified how staff should manage known ligature risks. During this inspection, we saw this remained the case on the eating disorder ward. The ward staff completed weekly environmental checklists, but the section about ligatures being present was blank. When asked, staff were not able to clearly articulate the location of ligature risks on the ward and how they would minimise the risks for patients.
- The ward complied with guidance on same-sex accommodation. There were two separate floors with bedrooms that could be assigned for male or female use. All bedrooms were en-suite, so patients could wash and use the bathroom in private, without passing through communal areas. There were lounge areas that could become single-sex areas as required.
- At the last inspection of the hospital in February 2017, we found that ward staff did not all have adequate access to systems to raise an alarm. During this inspection, all staff and patients had easy access to nurse call systems throughout the ward. Patient bedrooms and en-suites all had nurse call alarms that were placed in an accessible position.
- An external specialist provider completed a fire safety assessment in June 2017.This assessment concluded that the 'risk to life from fire at these premises was moderate'. It gave a list of actions to complete immediately, within one month and within three months. We were told that some actions had been completed, but there was no clear record of this and so it was not possible to be assured about fire safety at the hospital. In addition, we observed that patients had placed towels over a number of bedroom doors to prevent them from slamming shut and to minimise disturbance during nightly observations. This would compromise safety in the event of a fire.
- Comprehensive portable electrical appliance checks were taking place during the time of the inspection. This was previously carried out by in-house staff, but was now contracted out to an external company.

Maintenance, cleanliness and infection control

- Cleaning staff worked across the hospital. They did not have a list of tasks to complete on each shift. This meant there was a risk that some areas of the hospital might not be appropriately cleaned. Patient bedrooms, the

communal living room and the nursing office were visibly clean, had good furnishings and were well-maintained. The kitchen where snacks and supported meals took place was not visibly clean in all areas. For example, on kitchen surfaces and behind kitchen equipment. A hospital-wide patient survey from July to October 2017 showed that cleanliness received the second lowest score, with 85% describing it as satisfactory.

- There was one item of outdated food in the patients' fridge. Staff said there was no clear system for removing expired food.
- At the last inspection in February 2017, we found that hospital staff were not always managing infection risks appropriately and that actions from audits were not always followed up. During this inspection, the record of the most recent six monthly audit was not available. This meant we could not be assured the hospital had addressed this area of concern. We did see that disposable gloves, aprons and liquid hand gel were available for staff to use when preparing breakfast and snacks for patients.
- Records showed that checks for legionella took place on a monthly basis and that there were no significant concerns.

Clinic room and equipment

- We found several issues in the clinic room around the proper quality checking of equipment and storage of medicines. The clinic room was locked and not accessible to patients, but there were four containers of medication that were not stored securely in a medicines cupboard, which they should have been. Staff said these were left over from a patient who had been discharged. On the second day of the inspection we found that lorazepam had been moved from the medicines fridge compartment to the freezer compartment. This medication should not be stored at a very low temperature and could be painful to patients if administered in this way. Staff were not recording the minimum and maximum temperature of the fridge on a daily basis, which was not in line with good practice.
- To ensure medicines were kept at a temperature in line with manufacturer's guidance, staff were required to record the temperature of the clinic room each day. Records showed that staff noted each day that the air conditioner was set at 20 degrees Celsius, but they did not record the actual room temperature, which they should have done.
- In the clinic room, we found that over 15 items for taking bloods, such as needles, had expiry dates of 2015, 2016 and 2017. There were no records to indicate which staff carried out stock checks on equipment, so it was not clear when this last happened.
- There was a sharps bin in the clinic room for the safe disposal of used needles and other sharp items, but staff had not noted the date this was assembled, which they should have done in line with good practice in the management and disposal of sharps. In the weighing room, there was a sharps bin in use which was assembled in July 2004, which was a potential infection control risk.
- There was an oxygen cylinder for use in an emergency. Staff were required to check the cylinder was fit for use each day, but records showed this was only checked twice in December 2017 and January 2018 and three times in November 2017. There was no signage to show the oxygen cylinder was stored there and was highly flammable.
- There was no record book for how often staff calibrated and quality checked the blood glucose machine. There was no solution available to carry out quality assurance tests. This meant staff could not be assured that readings were accurate. This was a risk to patients, as blood glucose is monitored closely for patients with an eating disorder. This was fed back to staff on the day who ordered the necessary solution.
- Staff had access to resuscitation equipment and emergency drugs and records showed staff checked this regularly. However, they were not doing this thoroughly as the pads for the ECG machine had expired in December 2017 and had not yet been replaced. This was fed back to the provider during the inspection.

Safe staffing

Nursing staff

- The provider had calculated the number and grade of nurses and healthcare assistants required to deliver care to patients. Two qualified nurses worked each day,

supported by either a third qualified nurse or a healthcare assistant. At night, two qualified nurses provided cover. Duty rotas showed that the required number of staff worked on each shift.

- The charge nurse could adjust staffing levels daily to take account of case mix and patient need.
- Bank and agency staff did not work regularly on this ward. Across the hospital, in January 2018, the qualified nursing staff usage was 86% permanent staff and 14% bank staff. For healthcare assistants, 47% of the staff across the hospital were bank, although this was a small team of staff and there had been some long term sickness.
- Staffing levels allowed patients to have regular one-to-one time with their named nurse and these meetings were recorded clearly in patient notes.
- The provider reported sickness levels across the whole hospital, rather than for specific wards. The hospital-wide average for 2017 was 4%.

Medical staff

- The provider had 55 consultants with practising privileges, the hospital sometimes referred to these as 'admitting rights'.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. At the time of the inspection, nine of the 55 consultants had outstanding checks and for most there was a record of when these would be updated. This was overseen by the medical director, who, if needed, contacted the individual consultant. For a few consultants he had agreed delayed submission of documents, for example, if they were unwell. Ultimately he withdrew practicing privileges if checks were not satisfactorily completed and there were examples of when this had taken place.
- 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.
- There was adequate medical cover day and night and a doctor attended the ward quickly in an emergency.

Mandatory training

- Staff had received and were up-to-date with appropriate mandatory training. The provider closely monitored the completion of mandatory training. The completion rate for permanent staff was over 95%. This included adult and child safeguarding. Bank staff were also able to access the training. Managing violence and aggression and life support training were delivered face to face, with the rest of the mandatory training provided online.

Assessing and managing risk to patients and staff

Assessment of patient risk

- Staff did a risk assessment for every patient on admission and updated it regularly. Up-to-date risk assessments were present in each of the patient files we looked at. However, there was no evidence of any assessment for the risk of pressure ulcers. Patients and staff rated several areas of risk on a daily basis. Where a change in risk was reported, such as suicidal thoughts, staff increased observation levels and discussed this with patients and relevant staff.

Management of patient risk

- Patients said staff involved them in planning whenever risks changed. Family members and carers were also involved in the development of risk management plans when patients consented to this.
- There was limited space within the risk assessment tool for staff to outline the mitigation plan for each risk so they were restricted to a short phrase, such as 'meal management' or 'observations'. However, there was more detail in a daily handover sheet that staff completed each day. Therefore, staff had access to this information, but had to be aware of where to find it.
- Records showed staff did not use body maps to assess patient skin integrity and risks from pressure sores, which can be a risk for patients of very low weight. Patient notes had a section where this could be completed, but this was blank in the notes we looked at and staff had not indicated whether this was due to it not being necessary for the particular patient.

- Staff made recommendations about leave options to all patients, including informal patients, in order to manage risks of harm or excessive exercising. We saw two informal patients make requests to leave the ward outside the planned times and staff unlocked the door.

Use of restrictive interventions

- Staff did not often use restraint with this patient group. Monthly data on incidents showed that the number of restraints was not reported specifically at ward level. Types of incidents that were reported included absconding, illicit substances, self-harm.
- Staff had not used rapid tranquilisation on the ward in the 12 months leading up to the inspection.

Safeguarding

- Staff were trained in safeguarding, knew how to raise a safeguarding alert, and did that when appropriate.
- Staff followed safe procedures for children visiting the ward. Anyone under 18 was always accompanied by an adult when on the ward.
- Since January 2017, 19 safeguarding alerts had been made by the hospital. The compliance manager kept a log of safeguarding alerts and from this it could be seen that the referrals were appropriate. For some patients who were still in contact with the hospital, the provider had contacted the relevant parties to get feedback on the actions taken in response to the alert.

Staff access to essential information

- Staff used electronic patient records to record patient care. Information needed to deliver patient care was available to all relevant staff (including bank and agency staff) when they needed it and was in an accessible form.

Medicines management

- Staff did not always follow good practice in medicines management. Mainly in the storage and disposal of medicines. Staff did not use covert medication on the ward.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with national guidance for patients with an eating disorder.
- During the administration of medicines to patients, staff ensured patients' privacy, dignity and confidentiality were upheld.
- There was no information available to patients about how they could access a specialist pharmacist and/or pharmacy technician to discuss medication, which is a recommendation from the Royal College of Psychiatrists' Quality Network for Eating Disorders.

Track record on safety

- There were no serious incidents on the ward in the 12 months before the inspection.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and used the electronic system available to do this.
- The incident reports, which were hand-written documents, included space for staff to reflect on the learning from the incident. Some staff completed this very fully, and others had less insight into possible learning.
- The hospital compliance manager completed an analysis of all the incidents which considered the number and types of incidents as well as factors such as the time the incident took place. The analysis also reviewed the outcomes and areas for improvement. This report was discussed at the monthly quality performance management group.
- The compliance manager shared the analysis with the charge nurses on each ward, including the lessons learned. However, when asked, ward staff were mostly unable explain the incidents which had occurred and changes that had taken place as a result of the lessons learned. Incidents and learning were meant to be discussed at ward team meetings, but records of these meetings showed this was not happening consistently.
- Staff could access information about the duty of candour on the intranet, outlining their responsibilities to be open and transparent, and gave patients and families a full explanation if and when things went wrong.
- Where necessary, staff said they were debriefed and received support after incidents.

Requires improvement

Specialist eating disorder services

Are specialist eating disorder services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Records showed staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission.
- Staff created plans for care that related to needs identified at assessment. We saw that these were done from the day of admission and updated regularly thereafter. They showed evidence of patient involvement and patient wishes being taken into account. Records showed staff made individualised plans for patients and followed through with this on the ward. For example, extending post-meal support for individual patients and taking into account their wish not to see their weight.
- Staff assessed and monitored physical health needs that arose as part of the eating disorder, such as tachycardia, regularly checking bloods and vital signs and urinary symptoms, but records showed little evidence of support with wider physical health needs. For example, dental care and any general physical health issues.
- Records showed staff assessed patients for the risk of refeeding syndrome and sensitively and appropriately carried out any relevant treatment. For example, prescribing an appropriate meal plan, taking bloods more regularly and keeping the patient in a warm and restful environment.

Best practice in treatment and care

- Staff were aware of national guidance for the treatment of adults with an eating disorder. For example, National Institute for Health and Care Excellence (NICE) recommended treatments, such as cognitive behavioural therapy, individual eating disorder focussed cognitive behavioural therapy and access to psychoeducation groups about a specific diagnosis. The service offered these and also family therapy, art therapy and mindfulness. However, not all staff were aware of how to access NICE and other guidance, such as the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) so they could refer to them. There were no hard copies of guidance available to staff on the ward and they were not included as part of staff training and induction. This meant there were some recommended activities that staff were not carrying out. For example, the Sit Up Squat Stand test, which can be used as part of a physical assessment of patients with anorexia nervosa.
- There was no Management of Really Sick Patients with Anorexia Nervosa (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. This meant informal pathways and case by case referrals had to be relied upon. Staff said links with other hospitals could be hard to establish.
- The service employed an occupational therapist and dietitian as part of the multidisciplinary team, which is recommended for this patient group.
- The dietitian assessed nutritional status, prescribed individualised eating plans, and supported behaviour change 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, in order to get 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. Staff reviewed plans each week in 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 staff could describe how they reflected national guidance, but the documents did not reference any national guidance or evidence base. The document also lacked detail about how long a patient at each stage of treatment would be kept on the meal plan.

- 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.
- Staff had an understanding of the risks and management of refeeding syndrome.
- The ward had quick acting carbohydrate gels available on the ward for an emergency situation. The staff also stated they had sugar lumps that could be used, but this may be more uncomfortable for patients than the gel.
- Oral refeeding was the preferred method on the ward. There was a policy in place for the use nasogastric feeding, which was updated in September 2017. However, no patients had been naso-gastrically fed on the ward in over six months.
- Although records showed staff completed outcome measures regularly during patient admissions in order to capture data on severity of illness over time, there was little evidence of action being taken in response to the score. For example, one patient completed Beck's Depression Inventory, and their score indicated further action should be taken, but there was no evidence of follow up in their notes. Other tools included the 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 utilising the tools to their full potential.
- Staff did not regularly participate in clinical audit. Audits allow staff to identify areas of good practice and areas of improvement and put action plans in place to address them. They also allow senior staff to monitor the quality of care on the wards. Without these taking place, there was no clear method for senior staff to monitor this.

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 psychologists and a dietitian.
- Although the staff who worked on the ward displayed a knowledge and understanding of providing treatment to a patient with an eating disorder and had experience of working in this type of service, they were not supported by a formal core competency framework, regular specialist training or a specialist induction to the ward. A comprehensive training programme was not yet in place, although some specific training had been delivered on nasogastric feeding. A number of staff had applied to attend eating disorder conferences.
- 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. Staff said the eating disorder element of this induction was not comprehensive and they were not aware of a formal eating disorder competencies framework. The provider could not demonstrate how they made sure staff kept their specialist skills and knowledge up to date in all relevant areas.
- Three out of four patients told us that they had raised concerns about how effectively individual staff carried out constant observations. This is when staff keep patients within eyesight at all times in order to manage risks, such as self-harm behaviours. They indicated that staff did not always keep patients within eyesight.
- Staff did not keep a record of whether they had shared the ward booklet with new or bank or agency staff. This booklet provided a basic overview of the management of eating disorders and information about the ward's rules. For example, it advised that bathrooms should be kept locked and staff should not discuss their own

eating habits or make comments about weight and shape. It provided a clear and helpful guide to staff supporting meals. One patient said agency staff who worked over the Christmas were much less skilled at supporting meal times than permanent staff, indicating they had not become familiar with the booklet's contents.

- At the last inspection of the hospital in February 2017, we identified that the provider needed to implement a supervision policy and ensure that nursing staff received regular supervision. During this inspection, we found that since July 2017, the service had been working on this. Supervision compliance for staff on the ward had improved from 36% in July 2017 to 92% in December 2017. The service was still embedding this practice at the time of inspection, but staff said they felt supported. Staff working during the days could access a group supervision group run by the lead therapist each Monday. We observed this group and saw it was well-led, facilitated with sensitivity, compassion and experience. Staff were able to raise dynamic issues, express different views and were respected by other attendees.
- Therapy staff received regular supervision from senior staff of the same discipline, in line with professional requirements.
- 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. For the three months before the inspection, there was a record of two meetings taking place.
- At the last inspection of the hospital in February 2017, we identified that the provider needed to ensure nursing staff received regular appraisal. During this inspection, across all wards, records showed that completion rates were very low. The provider was reviewing the appraisal process, including the introduction of a new recording format. They recognised that they needed to move away from a 'tick box exercise' and ensure this was a meaningful process for all the staff.
- At the last inspection of the hospital in February 2017, we identified that the provider needed to make sure there were effective systems in place to address concerns about poor performance. During this inspection, we saw that managers dealt with 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 and regularly attended these meetings with staff in order to be involved in 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.
- 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 training in the Mental Health Act (1983). The provider had relevant policies and procedures that staff could access.
  Low numbers of patients were detained under the MHA each year. In 2017 fewer than ten patients were detained on the ward.
- Patients had access to information about independent mental health advocacy and patients said that, when it was necessary, staff had facilitated access to a mental health advocate quickly.
- 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, for example by providing a poster on the door with this information. On one occasion we saw staff unlocked the door when two informal patients asked to leave the ward. However, two other informal patients said access to fresh air was dependent on when staff were free to escort them and they sometimes had to wait for staff availability. Care plans included recommendations about leave for all patients, whether they were formal or informal, which could have led to confusion without further explanation. Leave recommendations were based on individual risk

assessments and included the length of time a patient could leave the ward and whether they needed to be escorted. It was not clear from notes that this was just a recommendation in respect of patients who were not formally detained. Within the legal framework of the MHA, staff cannot legally dictate leave for informal patients. As the ward front doors were locked and could only be opened by staff, it was important that patients understood their rights. The ward did not systematically inform or remind informal patients of their right to leave the ward. At the previous inspection in February 2017, this was raised as a concern. This issue had not been addressed.

Good practice in applying the MCA

- Staff received training in the Mental Capacity Act.
- 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.
- Staff did not audit assessment outcomes or the application of the Mental Capacity Act on the ward in order to take action on any learning that resulted from it.

Are specialist eating disorder services caring?

Good

Kindness, dignity, respect and support

- Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time 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 well by making it as easy as possible for them to talk to staff about their illness and patients reported post-meal supervision was helpful.
- We observed a meal time and saw staff were supportive to patients. They provided direction and guidance in an appropriate way.
- Patients said staff treated them well and behaved appropriately towards them. They said staff had a good understanding of their needs and were able to identify when patients might need extra support. Patients said staff acted in the best interest of patients.
- Patients knew who their key nurse was, what support they could offer and said they felt comfortable approaching them at any time.
- Staff behaviours and patient records showed staff understood the individual needs of patients, including their personal, cultural, social and religious needs.
- Staff kept information about patients confidential. 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.

The involvement of people in the care they receive

Involvement of patients

- Patients said staff worked collaboratively with them to develop care plans and risk management plans. One patient said staff responded proportionately and with compassion to identified risks.
- Records showed staff involved patients in care planning and risk assessment.
- 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 confirmed staff recorded feedback and took action. Staff recorded patient feedback about their care given in community meetings in their individual case notes as well, so other staff could be aware of this when reading handover notes.

Requires improvement

Specialist eating disorder services

- There was a suggestions box available for anonymous written feedback in the lounge. However, this was not secure and anyone could access the suggestions which could some inhibit patients. 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 from July to October 2017 were positive in relation to care received from staff. Over 92% of patients reported positive treatment from nurses and therapists and 94% said they felt treated with dignity and respect.
- 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 patient's main family/carers were identified and contact details were recorded.
- Staff informed and involved families and carers appropriately and in line with patient wishes. Records showed 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 group that all family and carers could attend. This offered education and information on the nature, course and treatment of eating disorders.

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

(for example, to feedback?)

Requires improvement

Access and discharge

Bed management

- Patients were referred to the ward by individual 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. It did not outline how this worked for patients who were admitted under the Mental Health Act, who might not be agreeable to the admission. 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. Generally patients used the service for periods between two weeks and three months.
- 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. One of the four patients we spoke with said the admissions process was quite rushed and it would have been helpful to have more time to read the formal documentation provided.
- 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 documents stated 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 there was a lack of detail about longer term plans for care after discharge. Patients who required longer term care were commonly discharged to the NHS.

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, for example, electrocardiograms (ECGs).
- 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. Three of four patients we spoke with said there were not always enough staff available to facilitate leaving the ward for fresh air. Staff said there were plans in place to address this. The Royal College of Psychiatrists' guidance recommends that eating disorder wards provide direct access to outdoor space that is safe and offers seating. Patients said this was a negative change following the ward move three months earlier, as they used to be able to access a courtyard.
- The service had an information pack that could be 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. One of the four patients we spoke with said they were not given this information at any point, and it would have been very helpful and made the admission process easier for them.
- Patients had their own bedrooms. These were well furnished, in good condition and had minimal ligature risks. Bedrooms had well maintained en- suite facilities.
- Patients could personalise bedrooms and information about this was available in admission packs.
- 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 wifi on the ward.
- Food was prepared freshly on site at the main hospital restaurant and set meal plans ensured patients' personal nutritional and liquid intake needs were met, with vitamin supplements where necessary. Patient satisfaction questionnaires from across the whole hospital from July to October 2017 showed that only 67% of patients scored the cuisine as good or excellent. This was the lowest score recorded for any area. There was no breakdown at ward level, so it was not clear how the patients had scored it on this unit.

- Meals were varied and reflected individual cultural and religious needs.
- Since the move to the new ward location three months earlier, patients who accessed the hospital restaurant for lunch and dinner had to go outside then walk through the main hospital. Patients told us they found the walk unpleasant. This was because patients had to pass through corridors that were not clean and which contained old equipment. In addition, they had to pass the hospital patient smoking room.
- The restaurant was a chaotic environment for someone with an eating disorder. We observed one lunchtime meal there and saw there was a delay in the meal starting as the menu for the day had changed. Staff said delays were inevitable with the current system as self and non-self-portioning patients were ready to eat at different times, but had to wait for one another. Two of the four patients and one member of staff we spoke with said they would prefer meals to be eaten in the dining room on the ward, rather than move patients twice a day to the hospital restaurant.
- 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 the individual's care plan.
- 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. On Saturdays there were two optional groups available on the acute wards on the main hospital site. On Sunday an optional workshop on assertion and boundaries ran at the main hospital site between 2pm and 3pm.

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.

Meeting the needs of all people who use the service

- The service was accessible for patients with mobility needs or patients of 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.
- There was no written information, in English or other languages, available on the ward about general healthcare, local services, patients' rights or how to complain. Staff said they were unsure whose responsibility it was to order leaflets.
- Staff could access interpreters and/or signers where necessary.
- 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.
- 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. However, this was not carried out on the day the dietitian was on the ward so meal plans were subject to change once the dietitian had reviewed them. Too many meal plan changes are not conducive to the management of eating disorders. Feedback from patients was that involvement in meal planning was helpful in their treatment.

Listening to and learning from concerns and complaints

- The hospital had a positive culture of accepting verbal as well as written complaints. The detail of each complaint was recorded. When possible, verbal complaints were quickly addressed and the outcomes were discussed with the patient or their carer and then recorded on the complaints record.
- In total about 5-10 complaints were received each month across the hospital. The aim was for an acknowledgement to written complaints to be received by the referrer within 48 hours and a final response to be sent within 20 days. In most cases these timescales were met.

Requires improvement

Specialist eating disorder services

- The compliance manager responded to most of the written complaints, although sometimes the response was written by the hospital director or nursing services manager. When required, other professionals were asked for written feedback to contribute to the response. Most complaint responses were thorough and written in an appropriate manner. However, we found some areas for improvement. A few complaint responses did not respond to all the points in the original complaint. Some written complaints only received a verbal response when a written one would have been more appropriate. One response did not sound appropriately sympathetic. None of the responses explained what next steps the complainant could take if they were dissatisfied with the provider's response, such as the contact details for the independent sector complaints adjudication service.

Are specialist eating disorder services well-led?

Requires improvement

Leadership

- There was insufficient leadership displayed due to the lack of planning for the relocation of the ward. We found no evidence that anyone had completed an assessment of the new environment to identify any risks it might present, such as those associated with frail patients having to walk outside to access the restaurant in all weathers. Ligature risks were not identified or mitigations planned in advance. The new ward environment also meant patients lost direct access fresh air which is not in line with best practice guidance.
- The ward did not have a charge nurse and was led by a nurse in charge on each shift. There were four 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, who started in post in April 2017. This system meant there was a risk of inconsistent leadership and decision making across shifts and confusion about where responsibilities for certain tasks lay. Members of nursing staff, including the nurse in charge, were visible in the service and could easily be approached by other staff and patients.

Vision and strategy

- The provider displayed their values for staff and patients to see. We saw evidence of the values being applied. For example, staff treated people with dignity and respect, compassion and kindness and worked together as a team. In other areas, the provider's senior leadership team had more work to do to successfully communicate values to the frontline staff, such as ensuring medicines were stored and managed in way that is in line with high quality care.
- Staff did not have the opportunity to contribute to discussions about the future of the service, for example, in relation to bed numbers.

Culture

- There was not a culture of involving ward staff in making decisions or planning changes. Ward staff had been given less than four days' notice of the relocation of the eating disorders ward to a different building. There was no evidence that managers offered ward staff a formal opportunity to consider how the service would operate in the new environment. Ward staff said they were not consulted about risks associated with the move.
- A small number of staff said the short time frame for the move and lack of consultation had caused unhappiness in the team. However, staff were positive and proud about working on the ward and in their team. They said their team was creative and they were able to respond to the changing patient needs.
- Senior staff dealt with poor staff performance when needed.
- Staff did not receive appraisals, so there was limited opportunity for staff to formally discuss career development and how it could be supported.
- The provider collected staff sickness data across all wards and the average for 2017 was 4%. Rates were highest at over 6% in September and October 2017.
- The provider collected staff turnover data across all wards and the average for 2017 was 24%.

Governance

- The hospital overall 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, although the record of the November meeting showed that only a few areas were covered. 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.

- The structures in place did not ensure that key learning was shared effectively with the staff delivering the care. For example, learning from incidents and complaints was not always discussed with charge nurses and ward staff at meetings. Standard agendas were not in use to ensure important information was discussed.
- The assurance processes were not yet ensuring that areas for improvement were identified and addressed in a timely manner. Instead the provider responded in a reactive manner to regulators and other external stakeholders.

Management of risk, issues and performance

- Staff at ward level could escalate concerns when required through the monthly steering group. However, areas of improvement were not always shared and addressed effectively within the team. For example, actions relating to eating in the restaurant and planning meals had not been followed through.

Information management

- The hospital overall 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 confidentiality of patient records.
- Charge nurses had limited information to support them with their management role. For example, audits to reflect the performance of the service, staffing and patient care.
- There was evidence that the provider recognised when incidents needed to be reported to external bodies, including the CQC. However, the incident reports frequently did not contain enough information for the CQC to understand the exact nature of the incident and the actions taken by the provider. This meant that the inspector often needed to ask for further information and gave the impression that the provider was not being open and transparent about incidents, contrary to the approach expected from a well-led hospital

Engagement

- Patients within the hospital overall were asked to complete a patient satisfaction survey and the results were collated. This survey had been completed on paper, but from February will be available on-line. There was a target of a satisfaction score of 96% and from July to October 2017 this score was just missed. The survey results showed patients were positive about the treatment they received from nurses. In addition, there were comment boxes in each ward. Any comments received were passed to the hospital director. In some cases he responded to the individual patients but there was not systematic feedback to patients.
- An initial staff survey had taken place in late 2017. This showed that many staff were positive about working for their team and the hospital. However, it also indicated that the communication between the senior leadership team and some staff groups in the hospital, especially bank and sessional therapists, could be improved. The leadership team was considering how this could be addressed and they were planning to introduce a hospital newsletter.
- 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. Some information on the intranet was outdated though, and staff could not access up-to-date information. For

example, on a page for nurses, the most recent entries included nursing meeting minutes were from 2015 and there was information about a revalidation workshop from 2016.

Learning, continuous improvement and innovation

- Staff were not always given support to consider opportunities for improvements and innovation.
- Staff did not use quality improvement methods in their work. There were no quality improvement projects taking place on the ward.
- The ward did not participate in an accreditation scheme.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

Safety of the ward layout

- The ward was set out across two floors on the third and fourth floors. On the third floor there were 10 bedrooms, a lounge, laundry facilities, a small kitchen for patients, a bathroom, the nurses' office and consulting rooms. On the fourth floor, there were six bedrooms, a nurses' station and a lounge. On the first day of our visit, the area on the fourth floor was closed to patients, but this had opened by the last day (21 January 2018). All bedrooms had en-suite facilities. There were blind spots on both floors, and staff mitigated the risk presented by blind spots by assessing patient risk and use of regular observations.
- The ward was in the process of being upgraded and ligature reduction work was taking place. This included the replacement of bathroom fittings such as taps and doors. Despite this work the bedrooms and en-suite bathrooms still contained a significant number of ligature points, as did the wider hospital environment. Patients moved freely around the hospital for meals and to attend therapy groups. The ward completed environmental checklists which included consideration of ligature risks. Despite this, when asked, staff were not able to clearly articulate the location of ligature anchor points on the ward and how they would minimise the risks for patients, for example through increased observations.
- All bedrooms had en-suite facilities. This meant that patients did not have to pass bedrooms used by the opposite sex to reach bathrooms.
- The service had call buttons in all bedrooms. A panel in the nursing station indicated where someone had activated a call button. There were no call buttons in communal areas.

Maintenance, cleanliness and infection control

- All areas of the third floor ward were clean and well-maintained. However, on the newly opened fourth floor, the clinic room, which was in use was visibly dirty with dust and debris, and lounge furniture was stained.
- The service provided a disinfecting hand gel dispenser on the wall near the entrance to the ward. However, there was no evidence of hand hygiene audits being undertaken.
- Cleaning staff worked across the hospital. They did not have a list of tasks to complete on each shift. This meant there was a risk that some areas of the hospital might not be appropriately cleaned. The housekeeper told us that they cleaned patients' bedrooms each day, but did not keep records of this. The service carried out a deep clean of bedrooms after patients were discharged.
- The hospital completed two infection control audits a year. At the time of inspection, the infection control lead was on leave and there were no records of infection control audits available. The compliance manager told us that these were carried out six-monthly. This meant there was a lack of evidence that the provider was effectively managing risks from the spread of infection to ensure a safe environment for patients and staff.
- Furniture and mattresses across the hospital were mostly fabric and not designed to be easy to clean. Patients might be incontinent or have blood borne diseases, presenting an infection control risk.
- At the previous inspection in February 2017, we noted that staff were not monitoring the temperature of refrigerators for storing food and beverages in the patient areas. This was monitored by catering staff at the time of the current inspection.

Substance misuse/detoxification

- In June 2017 a fire safety assessment had been completed by an external provider with specific experience of undertaking this work. This assessment concluded that the 'risk to life from fire at these premises was moderate'. It gave a list of actions to complete immediately, within one month and within three months. We were told that some actions had been completed, but there was no clear record of this and so it was not possible to be assured about the fire safety at the hospital. In addition, we observed that patients had placed towels over a number of bedroom doors to prevent them from slamming shut. This would compromise safety in the event of a fire.
- Comprehensive portable electrical appliance checks were taking place during the time of the inspection. This had been carried out previously by in-house staff but was now contracted out to an external company.
- Records showed that checks for legionella took place on a monthly basis and that there were no significant concerns.

Clinic room and equipment

- The medicines storage cupboard on the fourth floor was visibly dirty with dust and debris during our inspection on 21 January 2018, presenting an infection control risk. It also included some blood tubes and dressings that had expired in September 2017.
- The third floor clinic room was visibly clean. The blood sugar solution used to calibrate the blood sugar monitor was kept beyond its date for use after opening, which may have made results unreliable.
- Staff carried out a weekly audit to check equipment on the emergency trolley, made daily checks on the defibrillator, suction machine and oxygen and ensured that equipment was calibrated appropriately.

Safe staffing

Nursing staff

- In January 2018 the qualified nursing staff usage in the hospital was 86% permanent staff and 14% bank staff. For healthcare assistants, 47% of the staff were bank, although this was a small team of staff and there had been some long term sickness.
- We looked at the recruitment checks for eight staff that had recently started working at the hospital**.** Of these, two staff had started working with no written references, four had only one reference and two had both references. All the staff had a completed disclosure and baring service (DBS) check and evidence of their professional registration where needed. A new system was being put into place to ensure recruitment checks were completed and updated as needed.
- On the substance misuse ward, there were set staffing levels depending on bed occupancy. These were the same in the day and at night. During the inspection (due to low patient numbers) there were two nurses on each floor, in addition to an extra nurse 'floater' who could support staff on any of the wards in the hospital or accompany patients to other hospitals if needed.
- The charge nurse told us that out of an establishment of 13 nurses, there were nine in post, with four vacancies, and both nursing assistant posts were filled. The charge nurse was part of the nursing rota, with only one day a week set aside for ward management tasks.
- Staff reported that they were rarely short staffed, and ward activities were rarely cancelled, with support from regular bank staff support, in addition to the 'floater' nurse.
- Staff frequently worked across the other core services in the hospital, including the acute wards, eating disorders and with children and adolescents. This helped maintain safe staffing levels across the hospital, but made it harder for staff to acquire specialist skills and knowledge in substance misuse. Staff told us that they had been provided with some in-house training from a substance misuse consultant. However, there were no records of this and they did not demonstrate a clear understanding of the risks in working with people who were undertaking a detox. They advised that more sessions were planned.

Medical staff

- The provider had 55 consultants with practising privileges, the hospital sometimes referred to these as 'admitting rights'. The hospital carried out a range of checks to ensure that each doctor was fit to carry out their role. This included checking 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. At the time of the inspection, nine of the 55 consultants had outstanding checks and for most there was a record of when these would be updated. This was overseen by the medical director, who, if

needed, contacted the individual consultant. For a few consultants he had agreed delayed submission of documents, for example, if they were unwell. Ultimately, he withdrew practicing privileges if checks were not satisfactorily completed and there were examples of when this had taken place.

- There were five key consultants admitting patients to the substance misuse ward. They conducted informal ward rounds with their patients. A ward doctor covered the third floor, eating disorders and children and adolescents ward. The fourth floor was covered by a ward doctor who also covered the acute wards. Out of hours, one doctor was on call to cover the whole of the hospital.

Mandatory training

- The provider was closely monitoring the completion of mandatory training. The completion rate for permanent staff was over 95%. This included adult and child safeguarding. Bank staff were also able to access the training. Training on managing violence and aggression and life support training were both delivered face to face and the rest used on-line training.
- At our previous inspection in February 2017, we found that staff working on the substance misuse and detoxification ward were not provided with formal specialist training to work in this service. At the current inspection, five registered nurses had not received sufficient specialist training concerning substance misuse. This placed patients at risk of harm as interventions to protect patients from harm were not consistently carried out. We spoke with five registered nurses, three of whom worked regularly on the substance misuse and detoxification ward. None of the nurses 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. They, and the medical director, confirmed that the ward treated some patients for opiate detoxification. Patients who periodically left the hospital during opiate detoxification treatment were not prescribed or supplied with naloxone in case of emergency. It may not be suitable for all patients, but the reason for not offering it was not recorded either. Failure to prescribe or supply it to patients who might benefit from it and to train family members and staff to use it placed some patients at serious risk of harm.
- Two registered nurses were unclear about the action they should take in the event that a patient experienced an alcohol withdrawal seizure. This placed some patients at risk of serious harm.

Assessing and managing risk to patients and staff

Assessment of patient risk

- A nurse and doctor completed a risk assessment for each patient when they were admitted. 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 stated whether the patient had consented to that level of observation.
- At the previous inspection in February 2017, we found that risk assessments did not include any details of harm the patient had experienced in the past. At the current inspection, we found that staff were recording more detailed histories of patients' risk and substance misuse. Risk assessments were updated daily, based on a discussion between the nurse and the patient about how the patient was feeling that day. Staff rated daily risks as low, medium or high. The nurse and the patient both signed the daily risk assessment. If staff identified any risks as medium or high, the staff created a risk management plan. This plan stated the nursing intervention that would be used to address the presenting risk and any restrictions on the patient's movement.

Management of patient risk

- At the previous inspection in February 2017, we found that the service did not provide emergency alarms for staff to call assistance. At the current inspection, the compliance manager had ordered alarms for all staff, but these had not yet arrived.
- From looking at records of patient incidents and speaking to staff and patients, it was evident that the presence of illicit substances was a significant challenge. On the addictions unit, patients found using illicit substances had their placement terminated in line with a written agreement completed at the start of their

admission. On the other wards there was a lack of clarity about the steps being taken to try and prevent illicit substances being bought into the hospital and used by inpatients.

- Nurses 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 present if staff searched their bedroom. If patients did not co-operate with searches, staff negotiated with them. If the patient continued to be uncooperative, the nurse informed the consultant. The consultant decided on the most appropriate course of action.
- At the previous inspection in February 2017, staff were not always clear about the whereabouts of patients who were at risk of harming themselves or others. At the current inspection, the service provided four levels of observation. General checks of patients took place every hour. Level two observations involved staff checking patients every 15 minutes. Level three observations involved the patient being in sight of a member of staff at all times, and level four required the patient to be within arms-length of a member of a staff. Nurses agreed the level of observation with the ward doctor and consultant. Nurses could not reduce the level of observation without the agreement of a doctor.
- In all nine patients' care and treatment records we inspected, there was no early exit plan specifying the information that should be provided to patients if they left treatment early. Patients are at increased risk of accidental overdose if they use heroin following detoxification, due to reduced tolerance to opiates. Patients ending treatment for alcohol detoxification early are at increased risk of alcohol withdrawal seizures or delirium tremens if they do not recommence alcohol use.
- One patient was admitted to the hospital for alcohol detoxification with a history of recent alcohol withdrawal seizures and other complications. This patient had twice daily observations of their pulse and blood pressure, reduced to once per day on the third day of detoxification. They were authorised to go on leave from the hospital for a full day with a friend on the third day of their detoxification treatment. This placed the patient at risk of serious harm.
- One patient's care and treatment records recorded that they were admitted for detoxification from multi-substance misuse, and had a history of overdose. They had no physical examination on admission or at any time up to our inspection visit on 21 January 2018, when they had been on the ward for four days, despite this being requested by the consultant in charge. Identification of physical health problems should form part of a comprehensive assessment for people receiving treatment in specialist alcohol services (Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, National Institute for Health and Care Excellence (NICE) 2011).

Use of restrictive interventions

- There were some blanket restrictions in place. These were consistent with providing a therapeutic environment for patient to complete their detoxification from drugs or alcohol. The service did not permit patients to bring drugs or alcohol onto the ward, or to use drugs or alcohol whilst on leave. The service did not permit patients to enter other patients' bedrooms. The service only permitted visitors between 5.00pm and 10.00pm. If patients were not compliant with the restrictions placed on them, their consultant was informed. The consultant made a decision on what action to take based on the specific circumstances of the patient and the incident.
- Patients who were not detained under a section of the Mental Health Act could leave the ward if they wished to do so. 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.
- Staff said that it was rare for any patient to require a physical intervention. Staff could not recall any incidents of restraint on the ward. Staff said that if they did require support with a specific incident, nurses from other wards would attend quickly.

Safeguarding

- Since January 2017, 19 safeguarding alerts had been made by the hospital. The compliance manager kept a log of safeguarding alerts and from this it could be seen

that the referrals were appropriate. For some patients who were still in contact with the hospital, the provider had contacted the relevant parties to get feedback on the actions taken in response to the alert.

- At the previous inspection in February 2017, we found that staff were not identifying any risk to children cared for by patients on the ward. At the current inspection, we found that this was a standard part of the assessment for new patients on admission, and safeguarding issues were routinely discussed at handover meetings. The service had a policy on safeguarding for children and for adults. This policy included the procedure staff should follow if they suspected abuse. Staff said they had received safeguarding training. Nurses told us that if they were concerned about a patient they would pass the information to the safeguarding lead for the hospital. Children were 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. The medical director was the Caldicott guardian for the hospital (senior person responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing).
- All information needed to deliver patient care was available to relevant staff when they needed it and was in an accessible form. If patients moved between teams information was also transferred.

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 they had been omitted). Variable doses for detoxification regimes were clear and signed by the prescriber. Pharmacists were not routinely involved in medicines reconciliation on admission but ward doctors we spoke with described how they would ensure they had confirmation of a patient's current medicines wherever possible before they prescribed for them. There was a culture of reporting all medicines errors.
- Medicines were stored securely and appropriately. Fridge temperatures were monitored daily and seen to be in range. However, the medicines fridge was not kept locked, and the oxygen was not labelled. All prescribed medicines were available for people when they needed them. Controlled drugs, which require additional security, were stored and recorded appropriately and nurses did daily checks.
- At the previous inspection in February 2017, we found that the ward did not hold a supply of adrenaline for anaphylaxis, which should be kept to hand wherever Pabrinex injections are administered. At the current inspection, we found that emergency medicines and equipment were available, including adrenaline and these were checked weekly to ensure they were correct and available for use. However, on the first day of inspection, no naloxone was kept on this ward for emergency use in the event of opiate overdose.

Track record on safety

- The provider notified the Care Quality Commission of six serious incidents in the last year. There was one inpatient death, one allegation of sexual abuse and four patients who seriously harmed themselves either shortly after discharge or whilst receiving outpatient care from the hospital.

Reporting incidents and learning from when things go wrong

- There was a positive reporting culture for incidents and about 40 incidents were reported each month by hospital staff across the hospital. The most common incidents related to the use of illicit substances and self-harm. Other incidents included patients absconding and medicines errors.
- Staff said that they completed incident forms when incidents occurred. These were passed to the charge nurse and the nurse in charge of the hospital at the time. Incident reports, which were hand-written, gave staff the opportunity to reflect on any learning from the incident.
- The hospital compliance manager completed an analysis of all the incidents which considered the number and types of incidents, as well as factors such as the time the incident took place. The analysis also reviewed the outcomes and areas for improvement. This report was discussed at the monthly quality performance management group.

Substance misuse/detoxification

- At the previous inspection in February 2017, we found that staff across the hospital were not always aware of the learning from incidents. At the current inspection, we found that the compliance manager shared the analysis with the charge nurses on each ward, including the lessons learnt. However, when asked, most ward staff were unable explain the incidents which had occurred and the changes that had taken place as a result. Incidents were meant to be discussed at ward team meetings, but records of these meetings showed this was not happening consistently.
- For serious incidents, the hospital appointed an external professional to lead the investigation or sought guidance from external legal advisors. The reports produced used a root cause analysis format and the recommendations in the reports appeared quite limited. The provider said they would also wait for feedback from the coroner to add to the recommendations.
- There had been a number of patient deaths for patients across the hospital, over the past year, including one suicide on the premises. A root cause analysis process was completed leading to a change to the daily risk assessment tool used by the wards. There was also a plan to consider the installation of closed circuit television.

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

Assessment of needs and planning of care

- At the previous inspection in February 2017, we found assessment on admission did not include detailed information relevant to the patient's use of drugs and alcohol and the service did not use a specific tool to assess the level of drug or alcohol dependency. At the current inspection, we found that staff used a more rigorous risk assessment format and used the severity of alcohol dependence questionnaire (SADQ) to determine the starting dose of medicines used to treat acute alcohol withdrawal and other specific tools for drug detoxification.
- At the previous inspection in February 2017, we found that patients at a high risk of blood borne viruses were not routinely offered a blood test to identify whether they carried a virus. At the current inspection, we found an improvement in this area, although there were still some gaps in recording of whether this had been offered.
- Staff were not monitoring waiting times for assessment on admission. The service operated two systems for recording patients' information. A paper file contained the initial assessment, care plan and some progress notes. The electronic record contained more comprehensive progress notes and daily risk assessments. Some consultants made records on the electronic system whilst others used the paper record. Operating two systems meant there was often duplication of records. There was also a risk that staff would not know where to find essential information in an emergency.
- The care plans we looked at were up to date, but of variable quality in terms of the level of detail. We found some generic detox plans, including a patient who was recorded as being on an antipsychotic medicine for their detox, which indicated a lack of knowledge by the staff completing the plan.
- Patients completed their own care plan document, but this did not feed into the nursing plan completed for each patient. Therefore the care plans used were not always person centred.
- Care records included admission guidelines, consent forms, property checks, drugs and alcohol screening, risk assessment, safeguarding issues, a therapy programme, correspondence, observations, medicine charts. However, we found that two of the nine care plans we inspected were incomplete, with only generic care plans in place. These two patients were known to have mental health issues, but there was no relevant care plan to support for this.

Best practice in treatment and care

- Staff used a number of different tools to monitor people's withdrawal symptoms. However, they did not always use the correct tool for the particular substance. For example, staff were monitoring a patient on alcohol detox using the Clinical Opiate Withdrawal Scale (COWS) although they had no history of opiate use, and with no Clinical Institute Withdrawal Assessment for Alcohol, the validated tool, in place. This meant that the patient was not having their alcohol withdrawal symptoms assessed using a recommended validated tool to determine the need for any detoxification medicines. We also found a

patient on a detox from cannabis, being monitored using the COWS tool. Staff were not using the correct tools, which may have impacted on the safety of patients on detox.
- One patient had been prescribed night sedation (which is addictive), without a rational for the prescribing regime. There was no evidence that sleep hygiene had been attempted first. Night sedation continued to be administered at the same dose, even after the patient slept through one night without use of this medicine.
- The service provided a programme of psychological therapies facilitated by therapists. During the week the service provided a range of therapeutic groups for patients depending on their needs. These covered topics including anger management, relationships and relapse prevention. The service supported patients to complete the first three steps of the 12-step recovery programme. The service also provided groups for cognitive behavioural therapy, yoga and mindfulness. Free aftercare for addictions patients after discharge from the hospital was available in the form of weekly group therapy sessions.
- Patients had access to physical healthcare. Nurses regularly carried out physical observations. If a patient required specialist care and treatment they were referred to a specialist doctor at a local hospital and supported to attend appointments if necessary. However, one patient, who had been on the ward for four days, did not have all physical observations carried out, despite this being requested by the consultant in charge on admission.

Skilled staff to deliver care

- At the previous inspection in February 2017, we found that staff were not provided with formal specialist training to work in substance misuse. At the current inspection, we found that a brief induction was offered to all new staff by the human resources team. The teams that staff were joining also offered a more in-depth training. This varied between teams and they did not all have an induction checklist. Staff from the substance misuse ward also worked on all of the other wards in the hospital when required to provide cover.
- In the substance misuse ward a provider for specialist training had not yet been identified. In the meantime some in-house training had been delivered by the clinical staff working in the service.
- The nursing services manager had proposed an on-line training programme with the Royal College of Nursing as a way of delivering on-going learning and development for the nursing staff. This had not yet been approved.
- At the previous inspection in February 2017, we found that staff were not receiving regular supervision and appraisal. At the current inspection, the completion of supervision had improved on the substance misuse ward and records of a variable standard were kept. Supervision sessions took place approximately monthly.
- On both floors of the substance misuse ward the completion of staff appraisals was very low. The provider was reviewing the appraisal process and considering the introduction of a new recording format. They recognised they needed to move away from a 'tick box exercise' and ensure this was a meaningful process for all the staff.
- At the previous inspection in February 2017, we found that concerns about staff performance were not always being addressed effectively. At the current inspection, we found that there were systems in place to address poor staff performance.

Multidisciplinary and inter-agency team work

- At the previous inspection in February 2017, we found that there were not sufficiently effective systems in place to manage the risks for patients who did not consent to the service contacting their GP. This presented a number of risks, including the service not having independently corroborated details of the patient's medical history and the potential for the patient to have received medicines from the GP that they had not declared to the hospital. This heightened the risk of medicines being prescribed twice, leading to a potential overdose. At the current inspection, we found that permission to contact GPs was being requested on admission. 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 possible risks involved, when treating patients in these cases.
- The service did not hold multidisciplinary team meetings. Consultants usually visited patients three times each week. They met with their patients in private. At the end of their visit they made an entry onto the patient record.
- Handover meetings between nurses took place twice a day when there was a change of shift. The notes of these

meetings were detailed, providing key information about why the patient was admitted and an update on each patient's progress during the previous shift. Notes also included any changes to each patient's risk status, their observation level and their vital signs. A nurse attended the handover with the therapy team once a day. The therapy team recorded their notes on the electronic patient record.

- Hospital doctors met weekly and received supervision and support from a named consultant psychiatrist. The substance misuse service had a steering group, the minutes of their meetings were sent to all staff working on the ward.
- Staff team meetings had been held for the ward most recently in July and October 2017. Topics covered included consultant reviews, therapy assessments, the ward environment, training, withdrawal symptoms, observations, discharge and medicines.

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

- At the time of the inspection, there were two patients detained under the Mental Health Act (MHA) on the substance misuse ward. The remaining patients had completed an informal rights form on admission, informing them of their legal right to leave the hospital and to refuse treatment.
- On records for patients detained under the MHA there was evidence that patients were informed of their rights under section 132 and that the explanation was repeated as required.
- An independent mental health advocacy service was available and we saw evidence that all detained patients were referred to this service.
- The papers relating to detention were in good order and checked by the administrator and the medical director.

Good practice in applying the Mental Capacity Act

- The multidisciplinary team admission booklet contained the only record of patients' capacity to consent to admission and treatment. The admitting nurse completed the four stage capacity test by ticking yes or no to each question. If capacity was in doubt the compliance manager was contacted. We found no evidence of capacity assessments completed by treating clinicians in charge of the patients' care.
- The service completed an assessment of each patient's capacity to consent to admission and treatment during the initial assessment. The assessment form asked if 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. However, the capacity assessments being used were generic, and did not indicate for which particular decision capacity was being assessed, such as admission or taking prescribed medicines.
- Staff said they received training on the Mental Capacity Act. Staff said that if they had any questions about the Mental Capacity Act they would speak to 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 enters the hospital, this can 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.

Are substance misuse/detoxification services caring?

Kindness, privacy, dignity, respect, compassion and support

- Patients we spoke with were very happy with the nursing support they received. They described nurses as kind, considerate, compassionate and interested in them. Patients said that the staff managed the symptoms of their withdrawal well and that they felt safe throughout this process.
- Patients were positive about the therapy groups available to them and the support provided within the groups and on a one to one basis.
- We observed positive staff attitudes and behaviours when interacting with patients. Staff responded to patient requests promptly, they made an effort to get to know them and find out how they were.
- 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.

Substance misuse/detoxification

Involvement in care

Involvement of patients

- Nurses recognised that patients were often anxious when they arrived on the ward. In order to reassure them, a nurse spoke to patients about exactly what would happen during their admission and answer any questions.
- Care plans were recovery orientated. Patients were asked to complete a care plan for their admission. However, information from these was not integrated into the care plan completed by nursing staff for each patient. Daily risk assessments were completed collaboratively by nurses and patients.
- Patients could access an advocacy service. Contact details of the advocacy service were displayed on notice boards.
- Community meetings provided an opportunity for patients to give feedback and discuss any concerns they had about the service. These were held on a weekly basis and staff made a record of their content. Issues discussed at recent meetings included guidelines for patients, maintenance issues, meals, staff escorts, medicines, agreed leave.
- There were notices and information leaflets on both floors of the ward. These included information about activities, an opportunity to meet with the pharmacist, group rules, community meetings, aftercare groups, and local alcoholics or narcotics anonymous groups.
- The service asked patients to complete an inpatient satisfaction survey. This survey asked them to rate their experience of admission, the environment, care and treatment and outcomes of their treatment.

Involvement of families and carers

- Families and carers were welcome to visit the ward during visiting hours, if patients wanted them to do so.
- The service facilitated a family support group one evening each week.
- The service also held a family day once monthly, including information about the best ways to support patients working towards recovery.

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

Access and discharge

Bed management

- There was an admission checklist in place for new patients.
- 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 within the hospital.

Discharge and transfers of care

- Most patients were discharged to private outpatient follow up.
- For patients discharged during the inspection, the duty doctor completed a discharge summary. However, ward staff told us that they did not have access to the discharge plan completed by the patients' consultant, which contained other information.

Facilities that promote comfort, dignity and privacy

- Both floors of the ward had a patient lounge and kitchen, a laundry room, a clinic room and a consulting room. 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.
- There were facilities for patients to store their belongings securely.
- Patients were allowed to use their own mobile phones and computers and there was access to the internet.
- Patients had unrestricted access to a garden within the hospital until 9.30pm.
- The hospital permitted smoking in a designated area.
- The hospital restaurant provided a wide choice of good quality food.
- Patients were able to make hot drinks and snacks on the ward. Ward kitchens were equipped with a fridge, kettle, microwave, water cooler and a toaster.

Substance misuse/detoxification

- There was a comprehensive programme of therapies and activities throughout the week, including weekends. These included access to the hospital gym, massage therapy, mindfulness, drama, dance therapy, anger management, chi kung (a martial art), art therapy, relapse prevention and recovery, managing change and cognitive behavioural therapy.

Patients' engagement with the wider community

- Patients had access to local alcoholics anonymous and narcotics anonymous groups and were encourage to attend these 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

- There was a lift up to both floors of the ward. This meant the service could be accessed by people using a wheelchair.
- This was an international service that admitted patients from across the United Kingdom and from other countries. A number of patients were from the Middle East. The service routinely provided information in other languages and arranged interpreters.
- The service displayed information about treatment, patients' rights, advocacy services and advice on how to complain on notice boards on the ward.
- 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 requirements and preferences of the patients.
- The service could arrange appropriate 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.
- The hospital had a positive culture of accepting verbal as well as written, complaints. The detail of each complaint was recorded. Whenever possible, verbal complaints were quickly addressed and the outcomes were discussed with the patient or their carer and then recorded on the complaints record.
- In total about 5-10 complaints were received each month. The provider aimed to acknowledge written complaints within 48 hours) and to provide a full response within 20 days. In most cases these timescales were met.
- The compliance manager responded to most of the written complaints, although sometimes the response was written by the hospital director or nursing services manager. When needed, other professionals were asked for written feedback to contribute to the response.
- Most complaint responses were thorough and written in an appropriate manner. However, we found some areas for improvement. A few complaint responses did not respond to all the points raised. Some written complaints only received a verbal response when a written one would have been more appropriate. One response did not sound appropriately sympathetic. None of the responses explained what next steps the complainant could take if they were dissatisfied with the response, such as the contact details for the independent sector complaints adjudication service.

Are substance misuse/detoxification services well-led?

Leadership

- Staff said that senior staff visited the ward regularly and managers were approachable and supportive.
- Staff told us that they were not aware of any bullying or harassment within the service.
- Staff knew how to use the whistle blowing process and said they could raise concerns without fear of victimisation.
- Staff said they were happy in their work and that staff morale across the team was high. Staff said the team worked well together and there was a strong sense of mutual support.

Vision and strategy

- Across the hospital staff demonstrated the organisation's values of respect, compassion, commitment, teamwork and recognition throughout their work. Patients spoke very positively about the respect and compassion they displayed.

Substance misuse/detoxification

- Staff described improvements in the quality of their work, due to changes that had been put in place since the previous inspection, including more rigorous assessment of new patients on the ward.

Culture

- Nurses said they spoke to the charge nurse if there were any issues they needed to raise.
- An initial staff survey had taken place in late 2017 across the hospital. This showed that many staff were positive about working for their team and the hospital. However, it also indicated that the communication between the senior leadership team and other staff in the hospital, especially bank and sessional therapists, could be improved. The leadership team were considering how this could be addressed and were planning to introduce a hospital newsletter.
- Opportunities for staff to offer views on the service were limited due to the infrequency of team meetings.

Governance

- The hospital overall 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, although the record of the November meeting showed that only a few areas were covered.
- The structures in place did not ensure that key learning was shared effectively with staff delivering the care. For example, learning from incidents and complaints was not always discussed with charge nurses and ward staff at meetings. Standard agenda items were not in use to ensure important information reached all the staff.
- The assurance processes were not yet ensuring that areas for improvement were identified and addressed in a timely manner. Instead the provider was responding in a reactive manner to regulators and other external stakeholders.
- Staff were not receiving annual appraisals, but management were in the process of reviewing the appraisal system to make sure it was more meaningful.

Management of risk, issues and performance

- At the previous inspection in February 2017, we found that the provider did not have an effective system for grading incidents and accidents to quickly identify those that were serious, nor did they systematically share 'lessons learned' with staff. At the current inspection, we found that there was a strong culture of reporting incidents and accidents. These were assessed by senior management who identified any learning to prevent a reoccurrence. However, this learning from these was still not always shared with relevant staff across the hospital.
- Staff completed audits of daily and nightly duties to check that key tasks were carried out.
- All care plans were audited twice weekly by night staff to ensure they were up to date and of sufficient quality.

Information Management

- At the previous inspection in February 2017, we found that the provider was not completing all statutory notifications to the Care Quality Commission (CQC), including allegations of abuse. At the current inspection, there was evidence that the provider recognised when incidents needed to be reported to external bodies, including the CQC. However, the incident reports frequently did not contain enough information for the CQC to understand the exact nature of the incident and the actions taken by the provider. This meant that the inspector often needed to ask for further information and gave the impression that the provider was not being open and transparent about incidents, contrary to the approach expected from a well-led hospital.

Engagement

- Across the hospital, patients were asked to complete a patient satisfaction survey and the results were collated. This survey had been completed on paper, but from February 2018 will be available on-line. There was a target satisfaction score of 96% and from July to October 2017 this score was just missed. The survey results showed patients were positive about the treatment they received from nurses. In addition there were comment boxes in each ward. Any comments were passed to the hospital director. In some cases he responded to the individual patients but the findings did not feed systematically into patient feedback processes.

Learning, continuous improvement and innovation

- The hospital was working towards gaining accreditation with the Royal College of Psychiatrists for some of the core services they provided.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take 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 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.

Action the provider SHOULD take to improve

- The provider should ensure that an appropriate level of detail is provided for all incidents reported to the CQC.

Outstanding practice and areas for improvement

- The provider should ensure that inductions of new staff on each ward are reviewed to ensure they address all the necessary areas.
- The provider should ensure that they review procedures and processes to reduce illicit substances being brought into the hospital and make sure these are followed by all staff.
- The provider should ensure that capacity assessments are clear about the particular decision for which each patient is being assessed, such as admission or taking prescribed medicines.
- The provider should ensure that all care plans are complete, covering all areas of need identified and individualised for each patient, instead of using generic care plans.
- The provider should ensure when patients complete their own care plan, this is used to inform the nursing plan completed for each patient.
- The provider should ensure they continue to embed monthly supervision practice.
- The provider should ensure weekly meal plan meetings are held on a day when the dietitian can attend, in order to minimise changes to plans which could cause distress to patients.
- The provider should assess whether the arrangements for eating two meals a day in the hospital restaurant are effective and conducive to the support of patients with an eating disorder.
- The provider should ensure the suggestions box can only emptied by appropriate staff members, so patients can provide anonymous feedback if they wish.
- The provider should ensure monthly incident analysis includes information about numbers of restraints.
- The provider should ensure there are relevant information leaflets available to patients on each ward.
- The provider should ensure that staff are aware of infection control audits and act on their findings.
- The provider should ensure that patient records are kept locked away at all times when not in use.

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 11 HSCA (RA) Regulations 2014 Need for consent The provider had not ensured that informal patients on the eating disorders ward had clear information about their right to leave the ward and access fresh air daily. This was a breach of regulation 11(1)

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. The provider had not yet provided staff with an alarm system to summon assistance in an emergency. Staff were not clear about the ligature risks and management plans on each ward, in order to do all that was reasonably practical to mitigate risks. Staff did not follow best practice in the proper and safe management of medicines, including safe storage, administration, and monitoring of medicines and devices.

This section is primarily information for the provider

Requirement notices

The provider had not fully addressed actions from a fire risk assessment within the deadline set, and had not addressed the fire risk posed by patients placing towels over their bedroom doors.

The provider could not demonstrate how it was assessing the risk of and preventing, detecting and controlling the spread of infections. Clinic rooms were not kept clean at all times. The fabrics of bed mattresses, sofa cushions, and carpets, could not easily be kept clean.

On the substance misuse wards, patients undertaking detoxification were not sufficiently protected from harm, including restrictions on leave from the hospital, and physical health monitoring. There was no early exit plan specifying the information that should be provided to patients if they left treatment early.

The provider was not ensuring that staff working on the substance misuse wards were sufficiently trained in interventions to protect patients from harm. Staff were not aware of the purpose of the medicine naloxone (a potentially life-saving medicine when used in settings associated with opiate misuse and overdose) and patients who left the hospital during opiate detoxification treatment were not prescribed or supplied with naloxone and trained in its use. Staff were not clear about the action to take in the event of an alcohol withdrawal seizure.

These were breaches of regulation 12(2)(b)(c)(g)(h)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Requirement notices

The provider did not always follow effective systems to ensure complaints were responded to appropriately, including provision of details on how to escalate concerns if unsatisfied with the response.

This was a breach of regulation 16(2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not have robust governance and quality assurance processes in place to identify areas for improvement in a timely manner.

The provider did not have systems in place to ensure patient and staff safety when a ward was relocated.

The provider had not acted on a recommendation from the previous inspection which required them to have an effective system in place to ensure staff were able to discuss and learn from incidents.

The provider was not ensuring that staff team meetings were held on a regular basis and had standard agenda items related to maintaining and improving quality and safety.

This was a breach of regulation 17(1)(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

The provider had not ensured that staff received sufficient training and support for their role.

Staff did not receive specialist training in supporting people with an eating disorder, or substance misuse issues. Relevant staff were not clear about the validated tools to use for patients on detoxification from different substances.

The provider did not ensure staff had access to regular appraisals.

This was a breach of regulation 18(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had not completed necessary recruitment checks for all staff. This was a breach of regulation 19(3)(a)